	MEDICARE & MEDIC	_				011	15 110.0900 0091
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIC	00	COMPI	LETED
			1	LDING		05/11/2	011
			B. WIN			1 30. 1.72	- * •
NAME OF P	ROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP CODE		
	no (IBEN ON SOITEE			2075 R	IPLEY STREET		
LAKE PA	RK RESIDENTIAL	CARE INC		LAKE S	STATION, IN46405		
avo in	CLD O () DV (CTATE AND DEPLOYED VOICE	-	ID.	1		075
(X4) ID		STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0000							
	This visit was fo	or the State Licensure	R	0000			1
	Survey. This visit also included the			7000			
	Investigation of	Complaint 00085473.					
	Complaint Num	ber 00085473:					
	•	o deficiencies related to					
	the allegation are	e cited.					
	Survey Dates: N	May 9, 10, &11, 2011					
	~ · · · · · · · · · · · · · · · · · · ·	, , , , , , , , , , , , , , , , , ,					
	Facility Number	·· 001136					
	•						
	Provider Numbe						
	AIM Number: N	N/A					
	Survey Team						
	Heather Tuttle, I	ON T.C					
	•						
	Janet Adams, R.	N.					
	5/9 & 5/10/11						
	Kathleen Vargas	, R.N.					
	5/9 &5/10/11	, · · · ·					
	JI J CC JI 10/11						
	0 5 1=						
	Census Bed Typ	e:					
	114 Residential						
	114 Total						
	Cancus Davor Tr	ma:					
	Census Payor Ty	/pc.					
	114 Other						
	114 Total						
	Sample: 11						
	•						
	Supplemental Sa	ample: 13					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

001136

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

IFZP11

Facility ID:

(X6) DATE

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		onstruction 00	(X3) DATE	ETED
			B. WINC			05/11/2	011
	PROVIDER OR SUPPLIER			2075 R	ADDRESS, CITY, STATE, ZIP CODE IPLEY STREET STATION, IN46405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	REGULATORY OR These State Residin accordance with accordance accordance with accordance acc	dential Findings are cited th 410 IAC 16.2. pleted on May 116, 2011 by st immediately consult the ian and the resident's legal en the facility has noticed: ecline in the resident's or psychosocial status; or treatment significantly, that ntinue an existing form of dverse consequences or to form of treatment. record review fiews, the ided to ensure ent's physician ptly notified of an condition pain and a new expected finedication, vailability of an			Deficiency #: R036Resident Affected: #2, #4, #51. What corrective action (s) will be accomplished for those resident found to have been affected the deficient practice? Resident practice? Resident practice and what corrective action for procrit. Re #5's physician has been not of fall incident. Resident #4's physician was notified of not administration of Procrit. Re #5's physician has been not of the medicaid required authorization which led to the delivery of Zithromax.2. How the facility identify other resident having the potential to be affected by the same deficient practice and what corrective actions be taken? All residents have potential to be affected by the alleged deficient practice.	s dents by lent ified s n sident ified dents fected ce will de the nis	
	antibiotic pharmacy	from the for 3 of 11			Residents' medical records will be audited randomly every month to ensure compliance.3. What		

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If continuation sheet

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU COMPLE	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	- 1	LDING	00	05/11/20 ⁻	
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			2075 RI	PLEY STREET		
LAKE PA	RK RESIDENTIAL (CARE INC		LAKE S	STATION, IN46405		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	residents 1	reviewed for			measures will be put into pla what systemic changes the f		
	physician	notification in			will make to ensure that the deficient practice does not		
	the sample	the sample of 11.			recur? Nurses will be in serv on notifying physician of any		
	(Residents	s #2, #4, and			changes in condition, non- availability of medication,		
	#5)	,			administration of medication resident falls.4. How the	and	
	,				corrective actions will be monitored to ensure the defi		
				practice will not recur?The Director of Nursing or	ctice will not recur?The ector of Nursing or		
	i manigs merade.				designee will randomly chec (10) percent of residents clin		
	1. The red	cord for			records on a weekly basis an verify notification of physicial	nd	
	Resident #				all changes in condition, falls, availability of medication and administration of medication. Monitoring will be ongoing.5. By	5,	
		on 5/9/11 at					
	10:00 a.m				what date the systemic chan will be completed? June 23,	ges	
					wiii be completed. Care 20,	2011	
	resident's	diagnoses					
	included,	but were not					
	limited to,	, weakness,					
	high blood	d pressure,					
	anemia an	d congestive					
	heart failure.						
	11001110110	· ·					
	Nursing P	rogress Notes,					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE S COMPL	
			A. BUII B. WIN			05/11/2	
NAME OF F	ROVIDER OR SUPPLIER		_		ADDRESS, CITY, STATE, ZIP CODE		
LAKE PA	RK RESIDENTIAL (CARE INC		1	IPLEY STREET STATION, IN46405		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	dated 10/9	9/10 at 3:30					
	a.m., indic	cated the					
	resident h	ad complaints					
	of pain an						
	pain pill.	The resident					
	indicated	at that time,					
	that she ha	ad rolled out of					
	bed and her left side was						
	hurting he	er. The resident					
	refused to	go to the					
	hospital at	t that time.					
	Hydrocod	one APAP (a					
	pain medi	cation) 7.5/750					
	milligram	s was given to					
	the resider	nt for her pain.					
	The next of	documented					
	entry in N	urse's Notes					
	was on 10	/11/10 (2 days					
	later) at 10	0:00 p.m.,					
	which ind	icated the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CC AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING		00	(X3) DATE SURVEY COMPLETED 05/11/2011		
NAME OF F	PROVIDER OR SUPPLIER	• {	l	ADDRESS, CITY, STATE, ZIP CODE IPLEY STREET	•
LAKE PA	RK RESIDENTIAL	CARE INC	l l	STATION, IN46405	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
	resident h	ad complaints			
	of pain on	her lower left			
	side of her back. The				
	resident w	vas examined			
	by the nur	rse and was			
	found to h	nave a bruise on			
	her left back. There was				
	no documentation the				
	resident's	physician was			
	notified at	t that time. The			
	next docu	mented entry			
	in Nurse's	Notes was on			
	10/13/11 ((2 days later)			
	which ind	icated the			
	resident re	eturned from			
	the Physic	cian's office			
	with new	orders for a			
	hospital b	ed.			
	Review or	f Physician			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN B. WING		NSTRUCTION 00	(X3) DATE S COMPL 05/11/20	ETED	
	PROVIDER OR SUPPLIER		2	075 RII	DDRESS, CITY, STATE, ZIP CODE PLEY STREET TATION, IN46405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	Progress 1	Notes, dated					
	10/13/11,	indicated					
	"Contusion left chest,						
	hematoma	a left chest					
	area, poss	ible rib					
	contusion. Will ask for a rail for the bed.						
	Review of	f the Incident					
	Report Sta	atement, dated					
	10/9/11, ii	ndicated the					
	resident's	physician was					
	not notifie	ed of the fall					
	out bed.						
	Interview	with					
	Administr	rator on 5/10/11					
	at 2:45 p.1	m., indicated					
	the reside	nt's physician					
		een notified of					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S	ETED
			B. WIN	IG		05/11/2	011
NAME OF	PROVIDER OR SUPPLIER			2075 RI	ADDRESS, CITY, STATE, ZIP CODE PLEY STREET	-	
LAKE PA	RK RESIDENTIAL (CARE INC		LAKE S	STATION, IN46405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the fall or	the bruised					
	area until	the resident					
	went to th	e physician's					
	area until the resident went to the physician's office four days later. 2. The record for Resident #4 was reviewed on 5/9/11 at 12:10 p.m. The resident's diagnoses included, but were not limited to, lymphoma, iron deficiency, and anemia. Review of the 5/11 Physician Order Statement indicated there was an order for the resident to receive Procrit (a medication to treat low blood counts) 10,000 units injection weekly on Fridays. The Physician Order Statement indicated the medication was originally ordered on 11/26/10. The 1/11, 2/11, 3/11, and 4/11 Medication Administration Records were reviewed. On the 1/11 Medication Administration record the Procrit injection was circled as not given on 1/7/11 and 1/28/11. The 1/14/11 and 1/21/11 entries were blank. There was no documentation on the back of the 1/11 Medication Administration Record indicating the reason the medication was not given or not signed out as given.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP: 05/11/2	LETED	
	PROVIDER OR SUPPLIER		2075 R	ADDRESS, CITY, STATE, ZIP CODE IPLEY STREET STATION, IN46405	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	Record indicated not signed out as throughout the end documentation Medication Admindicating the read not signed out as The 3/11 Medicated circled as not given and 3/25/11. The documentation of Medication Admindicating the read not given. The 4/11 Medicated circled as not given. Medication Admindicating the read not given or not Murses' Notes for through 4/11 we not documentation notified of the Proceedings of the Processing Notes for through 4/11 we notified of the Processing Notes for through 4/11 we notified of the Processing Notes for through 4/11 we notified of the Processing Notes for through 4/11 we notified of the Processing Notes for through 4/11 we notified of the Processing Notes for through 4/11 we notified of the Processing Notes for through 4/11 we notified of the Processing Notes for through 4/11 we notified of the Processing Notes for through 4/11 we notified of the Processing Notes for through 4/11 we notified of the Processing Notes for through 4/11 we notified of the Processing Notes for through 4/11 we notified of the Processing Notes for through 4/11 we notified of the Processing Notes for through 4/11 we notified of the Processing Notes for through 4/11 we notified Notes for through 4/11 we notified Notes for through 4/11 we not throu	ation Administration I the Procrit injection was yen on 3/11/11, 3/18/11,				

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		05/11/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
IVKE DV	RK RESIDENTIAL (CADE INC	•	IPLEY STREET STATION, IN46405	
				1A11ON, 1N40403	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1710		ed on 5/10/11 at 1:45	1710		DATE
		Administrator indicated			
	1 *	ould have been notified of			
		ot being given as ordered.			
	the medication in	or being given as ordered.			
	3. The record for	Pacident #5 was			
		11 at 12:30 p.m. The			
		noses that included, but			
		·			
	were not limited to, congestive heart failure and diabetes.				
	There was as ent	ry in the Nurse's Notes,			
	dated 10/22/10 at	•			
		c. (doctor's name) office			
	· ·	sport. C/O (complains) of			
	cold symptoms."	sport. C/O (complains) of			
	cold symptoms.				
	There was a phys	sician's order, dated			
		dicated, "Zithromax (an			
	Í	g (milligrams), 2 pills x			
	1 day and 1 pill x				
	infection."	i i day o for office			
	The entry in the	Nurse's Notes dated,			
	1	a.m., indicated "Resident			
		for meds. New order for			
	·	ere, paper faxed over to			
		caid denied claim because			
		exceeded." An entry in			
	1 ^	s, dated 10/23/10 at 10:00			
		Pharmacy called back			
	l '	ithromax would not be			
		would not be able to call			
	1 covered and mey	modia not be dole to can		ļ.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 05/11/2	LETED
	PROVIDER OR SUPPLIER		2075 RI	ADDRESS, CITY, STATE, ZIP COD IPLEY STREET STATION, IN46405	Е	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	entry in the Nurs at 8:15 p.m., ind nurse's station. Resident became attempted to red. Continued reviewindicated the phythat the antibioti ordered for the reand could not be Interview with the Manager 5/10/11 the pharmacy set facility on 10/26 Administrator or indicated the phy	w of the Nurse's Notes ysician was not notified c Zithromax that was esident, was not available				

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		05/11/2011
NAME OF B	DOMINED OD CLIDDLIED		STREET	ADDRESS, CITY, STATE, ZIP CODE	!
NAME OF P	ROVIDER OR SUPPLIER		2075 F	RIPLEY STREET	
LAKE PA	RK RESIDENTIAL (CARE INC	LAKE	STATION, IN46405	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R0050		the right to manage their defined the facility			
		rvices, a resident may, by			
	_	ow the facility to execute all			
	or part of their financial affairs. Management				
	does not include the safekeeping of personal				
	items. If the facility agrees to manage the				
	resident 's funds, the facility must:				
	(1) provide the resident with a quarterly				
	accounting of all financial affairs handled by				
	the facility;				
(2) provide the resident, upon the resident 's request, with reasonable access, during normal business hours, to the written records					
		sactions involving the			
	individual resident				
		eparation of resident and			
	facility funds;				
		sident, upon written request			
		than fifteen (15) calendar			
		rt of the resident 's funds			
	given the facility for				
		otherwise required by			
		esident 's personal funds in			
		dred dollars (\$100) in an			
		ecount (or accounts) that is			
		of the facility 's operating credits all interest earned			
		funds to his or her account			
		ts, there must be a separate			
	· ·	ch resident 's share);			
	•	ent 's personal funds that			
		hundred dollars (\$100) in a			
	noninterest-bearin	g account, interestbearing			
	account, or petty of				
		maintain a system that			
		nplete, and separate			
	•	ding to generally accepted			
		les, of each resident 's			
	resident 's behalf;	trusted to the facility on the			
		ident or the resident 's			
	(o) provide the res	THE RESIDENCE OF			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD B. WING		00	(X3) DATE S COMPL 05/11/20	ETED
	PROVIDER OR SUPPLIER			2075 RIP	DRESS, CITY, STATE, ZIP CODE LEY STREET ATION, IN46405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	during normal bus the resident's ac (9) provide the resident reasonable acces hours to the writte transactions involves funds; (10) provide to the representative a gindividual financia resident or his or is statement of the in upon the request resident's legal reconvey, within thir a resident who hawith the facility, the final accounting or individual or probathe resident's est Based on and intervest and intervest of facility facil	sident or the resident 's we upon request with s during normal business in records of all financial wing the individual resident ' e resident or his or her legal uarterly statement of the l record and provide to the ner legal representative a individual financial record of the resident or the expresentative; and (11) ty (30) days of the death of s personal funds deposited e resident 's funds and a if those funds to the ate jurisdiction administering tate. record review	R00	50	Deficiency: R050Residents affected: Residents# 18, #19 #20, #21, #221. What correct action (s) will be accomplished those residents found to have been affected by the deficien practice? Residents #18, #19 #20, #21, and #22's persona funds accounts have the intecredited to their accounts and in the process of being notified the interest that has been credited. The bank has been contacted and the account has been changed to an interest bearing account. 2. How will the facility identify other residents having the potential to be affected and what corrective actions we	tive ed for e t t rest d are ed of he s ected e	06/23/2011

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Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED
			B. WING			05/11/2011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
LAKEDA	DI DECIDENTIAL	OARE INC			IPLEY STREET	
	RK RESIDENTIAL	CARE INC		LAKE S	STATION, IN46405	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
		· · · · · · · · · · · · · · · · · · ·	<u> </u>		be taken?All residents with	, , , , , , , , , , , , , , , , , , ,
sample of 13. (Residents					personal fund accounts in the	
	#18, #19, #20, #21, and				excess of one hundred (\$100 dollars have the potential to be	·
					affected by this alleged defici	
	#22)				practice. The Business Office	
					Manager will audit all resider personal funds accounts and	
	T. 1	1 1			credit the interest to all accou	l l
	Findings i	nclude:			in excess of one hundred (\$1	· · · · · · · · · · · · · · · · · · ·
					dollars. The residents will be notified of the interest	
	.				credited.3. What measures w	vill be
	Review of	f the Resident			put into place or what system	
	Funds acc	ount on			changes the facility will make ensure that the deficient prac	
					does not recur?The Corporate	
	5/10/11 at	: 1:15 p.m.,			office that is handling the inte	l l
	indicated	the following:			to be credited will be in servious on the regulations regarding	ced
	indicated	the following.			personal fund accounts. The	
					Business Office Manager tha	l l
	Resident #	418 had			handles the resident persona fund accounts in the facility v	
	IXCSIUCIII †	710 IIau			in serviced on the regulation.	
	\$1803.27	in the account.			Business Office Manager will	l l
	Resident #	410 had			ensure the interest has been credited to resident person fu	
					accounts in excess of one	
	\$625.00 ii	n the account.			hundred (\$100) dollars on a	ioo
	Resident #	420 had			quarterly basis. Business Off Manager and Corporate offic	
					staff will review each residen	
	\$873.47 in the account. Resident #21 had \$1121.23 in the account. Resident #22 had				personal fund statement to ensure interest has been	
					added.4. How the corrective	
					actions will be monitored to ensure the deficient practice	will
					not recur?The Business Office	
					Manager or designee will mo	nitor
	IXOSIUCIIL †	T 44 1144			the resident personal funds accounts on a quarterly basis	s and
					accounts on a quarterly basis	s and

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CO	NSTRUCTION 00	COMPI	LETED
			B. WING			05/11/2	U11
NAME OF I	PROVIDER OR SUPPLIER		I		ADDRESS, CITY, STATE, ZIP CODE		
LAKE PA	RK RESIDENTIAL	CARE INC	I		TATION, IN46405		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	\$962.57 ii	n the account.			will provide the information resident on a quarterly basis		
Review of the 2009 and 2010 bank statements for				or upon request. The Administrator will monitor ongoing for compliance.5. By what date the systemic changes will be completed? June 23, 2011			
	each of the listed						
		indicated no					
	interest had been						
	credited to their						
	accounts.						
	Interview with the Business Office Manager on 5/10/11 at 1:30 p.m., indicated she was able to access their account information online; however, the corporate office kept track of the amount of credits, debits, and interest for each of						

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	` ′	ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00		MPLETED
			B. WIN	G			1/2011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP C	CODE	
NAME OF I	ROVIDER OR SOLITEIER			2075 RI	PLEY STREET		
LAKE PA	RK RESIDENTIAL (CARE INC		LAKE S	TATION, IN46405		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	PPECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	AFTROFRIATE	DATE
	the accoun						
R0120	education and train advance for all per least annually. Train not limited to, reside control of infection accident prevention populations served administration, and appropriate, as foll (1) The frequency education and train accordance with the facility personned the facility personned inservice per caler of inservice pe	d nursing care, when lows: and content of inservice ning programs shall be in ne skills and knowledge of nel. For nursing personnel, at least eight (8) hours of ndar year and four (4) hours allendar year for nonnursing ne above required inservice ave contact with residents num of six (6) hours of training within six (6) (3) hours annually the needs or preferences, well impaired residents gain understanding of the of care for residents with ds shall be maintained and following: and location. the instructor. instructor. the participants. content of inservice. acknowledge attendance					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LDING	00	(X3) DATE COMPI 05/11/2	LETED
	PROVIDER OR SUPPLIER		P : ****	STREET A 2075 R	ADDRESS, CITY, STATE, ZIP CODE IPLEY STREET STATION, IN46405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE .	(X5) COMPLETION DATE
TAG	Based on and interv facility fa new empl six hours training w six month employme employee files revie	record review riews, the iled to ensure oyees received of dementia within the first as of ent for 2 of 5 s whose were ewed. (RN #1 ekeeper #1)	RO	TAG 0120	Deficiency: R120Resident Affected: RN#1 and Housekeeper#11. What corrective action (s) will be accomplished for those refound to have been affect the deficient practice? Housekeeper #1 completed the balance hours. RN#1 will complete balance of hours needed completion upon return from Medical leave. 2. How will facility identify other resident having the potential to be by the same deficient practice and what corrective action be taken? All hired employ within the last six months the potential to be affected alleged deficient practice. Employee files are being a to ensure the six hours of dementia training requirer met. 3. What measures will into place or what system	e sidents ed by has urs of ining the for om the ents affected etice as will ees have d by this All audited ment is I be put	06/23/2011
	files on 5/ a.m., indi- was hired	f the employee /10/11 at 9:30 cated RN #1 on 6/14/10 and eper #1 was 8/23/10.	changes the face ensure that the does not recur? Staff will be in some Dementia Training for all newly hire New employees to complete Dementia to complete D		changes the facility will m ensure that the deficient p does not recur?All admini Staff will be in serviced or Dementia Training Requir for all newly hired employ New employees will be re to complete Dementia Tra one (1) hour per month fo first six months of employ an employee does not con the training for that month will be suspended and sul termination. A new form w iinstituted to track each	ake to ractice strative the ement ees. quired ining r the ment. If mplete , they bject to	

001136

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		00	(X3) DATE S COMPL 05/11/20	ETED
	PROVIDER OR SUPPLIER		2	2075 RIF	DDRESS, CITY, STATE, ZIP CODE PLEY STREET TATION, IN46405	05/11/20	, i i
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL		PR	AKE STID EFIX FAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) employee's dementia training compliance.4. How the corre actions will be monitored to ensure the deficient practice not recur?Business Office Manager will audit the newly employee files monthly for Dementia Training and will retracking form to ensure compliance and will report findings to Administrator. Thi monitoring will be ongoing by Administrator or designee.5. what date the systemic chan will be completed? June 23,	ctive will hired eview s , By ges	(X5) COMPLETION DATE
	indicated employee completed six hour o	I the required f dementia within the first					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00		E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIEF		2075 R	ADDRESS, CITY, STATE, ZIP C IPLEY STREET STATION, IN46405	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	employm	ent.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/11/2011
	PROVIDER OR SUPPLIER		STREET A 2075 R	ADDRESS, CITY, STATE, ZIP CODE IPLEY STREET STATION, IN46405	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
R0121	employee of a facility using the Mantoux unless a previousl documented. The millimeters of indudate read, and by facility must assure (1) At the time of equation (1) At the time of equation (1) month prior to annually thereafte personnel of facility tuberculosis. The must be read prior work. For health chad a documented test result during the months, the baselishould employ the step is negative, a performed one (1) first step. The frequency depend on the risk tuberculosis. (2) All employees reaction to the skill have a chest x-ray laboratory examina a diagnosis. (3) The facility share of each employee employment-related (4) An employee vactive disease, (sy active tuberculosis to, cough, fever, in loss) shall not be putuberculosis is rule.	employment, or within one employment, and at least r, employees and nonpaid ies shall be screened for first tuberculin skin test to the employee starting are workers who have not d negative tuberculin skin he preceding twelve (12) ine tuberculin skin testing two-step method. If the first second test should be to three (3) weeks after the uency of repeat testing will a of infection with who have a positive in test shall be required to and other physical and ations in order to complete with symptoms or signs of any methods. If the first second test should be to three (3) weeks after the uency of repeat testing will a confinection with who have a positive in test shall be required to any and other physical and ations in order to complete with symptoms or signs of any methods of the supports of all the screenings. With symptoms or signs of any methods of the supports of signs of any methods are supports of signs of any methods and weight opermitted to work until	R0121	Deficiency: R121Residents affected: RN#1, CNA#1, an	
				CNA#21. What corrective a	ction

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
			B. WIN			05/11/20	011
					ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIE	R		2075 RI	IPLEY STREET		
LAKE PA	ARK RESIDENTIAL	CARE INC		LAKE S	STATION, IN46405		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	and interv	view, the			(s) will be accomplished for t residents found to have beer		
	facility failed to employ				affected by the deficient practice?RN#1 will complete		
	the second step Mantoux				Mantoux Test Procedure upo return from Medical Leave.	n	
	method a	fter the			CNA#1 and CNA#2 have completed the 2 Step Manto	ux	
	administr	ation of the			Process and are in compliance.2. How will the fa	acility	
	finat stars	Mantaux tast			identify other residents havin	g the	
	first step	Mantoux test			potential to be affected by th		
	for 3 of 5	employee			same deficient practice and corrective actions will be	wnat	
		1 2			taken?Newly hired employee	es	
	records re	eviewed.			have the potential to be affect		
	(RN#1 C	CNA #1, and			by this alleged deficient prac All newly hired employee file		
	` ′	i (i i i i j wii w			within last six months will be		
	(CNA#2)				audited.3. What measures w put into place or what systen		
					changes the facility will make		
					ensure that the deficient prac		
	Findings	include:			does not recur?The polices h		
					been reviewed with Administ		
					Assistant, Nursing Staff, and Management Staff and they		
	Review o	f the employee			are being inserviced on Man	toux	
		1 2			Method and the time restrain		
	files on 5/	/10/11 at 9:30			which steps must be comple when an applicant is hired by		
	a.m., indi	cated the			facility. The new applicant wi	ll be	
	1				given a return date to comple	ete	
	following:				the second step and if the applicant does not return on	the	
	RN #1 was hired on				date given, the employee wil		
	6/14/10 and received a				terminated. Facility staff not adhering to policy regarding		
					Mantoux Method will be		
	first stan	Mantouv test			disciplined.4. How the correct	tive	
	msi sicp	Mantoux test			actions will be monitored to		
					ensure the deficient practice	WIII	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE COMPI	
AND LEAN	or connection	IDENTIFICATION NONIBER.	A. BUI B. WIN	LDING		05/11/2	
NAME OF E	PROVIDER OR SUPPLIER		B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	RK RESIDENTIAL (1	IPLEY STREET		
(X4) ID		TATEMENT OF DEFICIENCIES		ID ID	STATION, IN46405		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	JE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	not recur?Business Office		DATE
	on 6/2/10.				Manager or designee will re		
	CNA #1 was hired on				all paperwork for new hires a will keep track of return date	s for	
	9/13/10 and received a first step Mantoux test on 9/11/10.				newly hired employees need the Second Step of Mantoux	c to	
					ensure compliance ongoing. what date the systemic char	nges	
					will be completed? June 23	, ∠∪۱۱	
	CNA#2 was hired on						
	12/10 and received a						
	first stet N	Intoux test on					
	12/4/10.						
	There was	s no second					
	step Mant	oux test					
	completed	l for any of the					
	above em	ployees within					
	2 to 4 wee	eks after					
	receiving	the first step.					
	There was no						
	documentation from the						
	previous 12 months that						
	they had received a						
	•						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
			B. WING		05/11/2011	
NAME OF F	PROVIDER OR SUPPLIER		l	ADDRESS, CITY, STATE, ZIP CODE		
LAKE PA	RK RESIDENTIAL	CARE INC	I	STATION, IN46405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	tuberculin	skin test.				
	Interview	with the				
	Assistant A	Administrator				
	on 5/10/13	l at 10:45 a.m.,				
indicated the mentioned						
	employees did not					
	receive a	second step				
	Mantoux	within 2 to 4				
	weeks after the first step.					
R0144	state of good repa	all be clean, orderly, and in a ir, both inside and out, and onable comfort for all				
	Based on	observation	R0144	Deficiency #144Residents affected: All 114	06/23/2011	
	and interv	iew, the		Residents1. What corrective action (s) will be accomplish those residents found to hav	ed for	
		iled to ensure		been affected by the deficier practice?Room 205- Curtain	nt	
	the environment was clean and in a state of good repair related to			laundered and spare curtain be ordered. Room 215 Door	s will	
				be sanded and painted; Scu marks removed; Bathroom w	ffed	
				cleaned; Caulking redone or bathtub. Room 220 Curtain		
torn wallpaper, chipped		aper, chipped		laundered. Room 124- Exha	ust	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

IFZP11

Facility ID:

001136

If continuation sheet

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
AND I LAIV	or connection	IDENTIFICATION NOMBER.		LDING		05/11/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PI	ROVIDER OR SUPPLIEF	₹			IPLEY STREET		
LAKE PAI	RK RESIDENTIAL	CARE INC		1	STATION, IN46405		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	*	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
IAG	_	loor frames,		IAG	fan vent cleaned; Bottom of	door	
	•	•			cleaned. Room 130 Wall par secured to wall.; Bottom of	per	
	cracked a	nd discolored			bathroom door repainted. Ro		
	caulking,	stained			handle replaced. Room 171		
	window c	urtains,			Shower bar replaced. Brick v repainted. Ceiling tiles above		
		door, dusty			vending machines cleaned. I frames between small and la	Door	
	•	•			dining room repainted.2. How	- 1	
	ceiling ex	haust vents,			the facility identify other residuals having the potential to be aff		
	paint chipped on walls,				by the same deficient practic	ce	
	marred an	nd rusty floors,			and what corrective actions when taken? All residents have		
		aucet missing a			potential to be affected by th alleged deficient practice. All		
		C			resident rooms are being		
	handle in	5 resident			checked for cleaning and represents issues by Environmental Ser	•	
	rooms on	the first floor,			Director or designee.3. What measures will be put into pla		
	3 resident	rooms on the			what systemic changes the f		
	second flo	oor, 2 of 2			will make to ensure that the deficient practice does not		
		oms, and 1 of 1			recur?All housekeeping and Maintenance staff will review	,	
					policies and procedures on cleaning and repairs.All		
	activity ar				Housekeeping and Maintena	ance	
	deficient j	practice had the			staff will be in serviced on Housekeeping concerns and	1	
	potential to affect the 114 residents residing in				Maintenance issues and that these concerns should be	l l	
					cleaned or repaired immedia	itely	
		•			and reported to the Environmental Services Dire	ector	
	the facility. (The first and second				as needed.4. How the correct	ctive	
					actions will be monitored to ensure the deficient practice	will	
l	•				not recur?The Environmenta		

	I '	OVIDER/SUPPLIER/CLIA FICATION NUMBER:	(X2) M	ULTIPLE CO	00	COMPL	
			1	LDING		05/11/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			2075 RI	PLEY STREET		
LAKE PA	RK RESIDENTIAL CARE	INC		LAKE S	STATION, IN46405		
(X4) ID PREFIX		ENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		T BE PERCEDED BY FULL ENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ	COMPLETION DATE
	resident floor	s, the small			Services Director will monito cleaning and repair concerns		
	and large Din	ing room,		weekly basis by making rodaily and checking 5 roon			
	and the Activ	ity room			week to ensure that resident rooms and common areas a	re	
	area.)				being cleaned and that repa have been completed in a tir		
	,				manner to ensure compliant Monitoring will be ongoing.5		
	Eindings in als	, da.			what date the systemic char	nges	
	Findings include:				will be completed? June 23	, 2011	
	1. During the						
	Environmenta	al tour on					
	5/10/11 at 9:4	0 a.m., the					
	following was	s observed					
	on the second						
	on the second	11001.					
	TP1						
	a. There were	e gray					
	stains on the	window					
	curtain in Roo						
	Two residents resided in this room						
	h The weed	TY O C					
	b. The wood	was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPI		
THIS TELLY	or colucterion	BENTH TOTAL TOTAL BENT	A. BUI B. WIN	LDING IG		05/11/2	
NAME OF F	PROVIDER OR SUPPLIER		<u>Б. W.I.</u>		ADDRESS, CITY, STATE, ZIP CODE		
	RK RESIDENTIAL			1	IPLEY STREET STATION, IN46405		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
	splintered	on the bottom					
	of the batl						
	Room 215	5. There were					
	gray and b	olack scuffed					
	marred are	eas on the					
	bathroom	floor. The					
	bathroom	walls were					
	dirty. The	re were pieces					
	of caulkin	g broken off in					
	the bathtu	b. Two					
	residents 1	resided in this					
	room.						
	c. There v	were brown					
	stains on t	the window					
	curtain in	Room 220.					
	One reside	ent resided in					
	this room.						
	When inte	erviewed at this					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE COMPI		
			B. WIN	IG		05/11/2	011
NAME OF F	PROVIDER OR SUPPLIER	- -			ADDRESS, CITY, STATE, ZIP CODE		
LAKE PA	RK RESIDENTIAL	CARE INC			TATION, IN46405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	time, the l	Maintenance					
	Director in	ndicated the					
	above area	as were in need					
	of cleanin	g or repair.					
	2. During	g the					
	Environm	ental tour on					
	5/10/11 at	9:55 a.m., the					
	following	was observed					
	on the sec	ond floor:					
	a. The wa	as an					
	accumulat	tion of dust on					
	the ceiling	g exhaust fan					
	,	oom 124. The					
		the bathroom					
		rusty. Two					
		resided in this					
		icsiucu III uiis					
	room.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/11/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE PLEY STREET STATION, IN46405	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	b. There	was an					
	accumula	tion of dust on					
	the ceiling	g exhaust fan					
	vent in Ro	oom 120. Two					
	residents	resided in this					
	room.						
	c. The wa	all paper was					
	peeling or	n the wall					
	corners ne	ext to bathroom					
	exit area i	n Room 130.					
	The paint	on the					
	bathroom	door frame					
	was chipp	ed. The					
		the bathroom					
	door was:	marred. One					
	resident re	esided in this					
	room.						
	-						
	d. The wa	all paper in the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING O5/11/20					
	PROVIDER OR SUPPLIER		2075 R	ADDRESS, CITY, STATE, ZIP CODE IPLEY STREET STATION, IN46405	•	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRIDEFICIENCY)	D BE	(X5) COMPLETION DATE
	bathroom	in Room 156				
	was torn.	A piece of the				
	faucet har	ndle was				
	missing of	n the sink.				
	Two resid	ents resided in				
	this room.					
	e. The ca the inside was black in Room for the she was rusty chipped o wall betw window a register ve	ulking along of the bathtub and discolored 171. The bar ower curtain The paint was n the brick een the nd the window				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE :		
THIS TELLY	or coluction	BENTH CATION NONBER	A. BUI B. WIN	LDING		05/11/2	
NAME OF F	PROVIDER OR SUPPLIER		B. WII		ADDRESS, CITY, STATE, ZIP CODE		
	RK RESIDENTIAL				PLEY STREET TATION, IN46405		
(X4) ID		TATEMENT OF DEFICIENCIES		ID I	·		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		erviewed at this					
	time, the l	Maintenance					
	Director is	ndicated the					
	above are	as were in need					
	of cleanin	g or repair.					
	3. During	the .					
	Environm	ental tour on					
	 5/10/11 at	: 10:30 a.m.,					
	the follow	•					
		C					
		in the Dining					
	rooms and	d the Activity					
	room area	as:					
	a. There y	were three					
	stained ce						
		C					
	above the	vending					
	machines	at the entrance					
	to the Act	ivity room.					
		. y = - -					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
			A. BUILDI B. WING	ING		05/11/20	011
	PROVIDER OR SUPPLIER		2	2075 RII	DDRESS, CITY, STATE, ZIP CODE PLEY STREET TATION, IN46405		
(X4) ID		TATEMENT OF DEFICIENCIES		ID T		1	(7/5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	b. The pa	int on the door					
	frames of the two door						
	between the	he small and					
	large dinii	ng rooms was					
	chipped.						
	When inte	erviewed at this					
	time, the I	Maintenance					
	Director in	ndicated the					
	above area	as were in need					
	of cleanin	g or repair.					
R0154	areas, common di utensils clean, free	Il keep all kitchens, kitchen ning areas, equipment, and e from litter and rubbish, good repair in accordance					
	Based on	observation	What Corrective action (c) will be		-		06/23/2011
	and interv	iews, the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
			B. WIN			05/11/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
				1	IPLEY STREET	
	RK RESIDENTIAL (STATION, IN46405	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
IAG		· · · · ·		IAG	the deficient practice?Dish	DAIL
	facility fai	iled to ensure			machine and ceiling of dish r	
	food was j	prepared and			were cleaned during survey. transportation carts were cle	aned
	served und	der sanitary			including wheels. PVC pipes white wall under the three	and
	conditions	s related to			compartment sink cleaned. Baseboard under the three	
					compartment sink cleaned. E	
	dusty and	dirty ceiling,			trash barrels cleaned. Food table cleaned. The area und	· · I
	dirty and g	greasy			wire racks were cleaned of	er the
		•			burned food. Top and bottom	n of
	transporta	tion carts, dirty			convection ovens cleaned. V	·
	floors dir	ty PVC pipes,			by convection oven cleaned. and grease on side and behi	I
	_	1 1			stove cleaned. The griddle w	
	greasy equ	aipment and			cleaned immediately during survey.2. How will the facilit	
	dirty oven	s, for 1 of 1			identify other residents havir	ig the
	kitchen ar	eas. This had			potential to be affected by the same deficient practice and	what
	the potent	ial to affect			corrective actions will be take All residents in the facility ha	ve
	_				the potential to be affected b deficient practice. Dietary St	· I I
	114 reside	ents who			were informed that kitchen n	
	resided in	the facility.			to be kept clean.3. What	
		•			measures will be put into pla what systemic changes the f	
	(The Mair	i Kitchen)			will make to ensure that the	domity
					deficient practice does not re	ecur?
		1 1			All Dietary staff will review policies and procedures on	
	Findings i	nclude:			cleaning kitchen equipment	and
	_				environment .Dietary Staff w	ill be
					in serviced by Dietary Super	
	1. During	the full			on cleaning schedule of kitch and equipment. 4. How the	ien
					corrective actions will be	
	Kitchen S	anitation Tour			monitored to ensure the defi	cient
					practice will not recur? The	
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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPL		
1111212111	or condition,		1	ILDING		05/11/2	
		<u> </u>	B. WIN		DDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIER			1	PLEY STREET		
LAKE PA	RK RESIDENTIAL	CARE INC		LAKE S	TATION, IN46405		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	-	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	on 5/9/11	at 9:20 a.m.,			Dietary Supervisor and Assi Dietary Supervisor will moni		
the following was				the cleaning of the kitchen a equipment and will ensure t			
	observed:				staff is adhering to schedule doing daily and weekly chec Staff not adhering to the cle	ks.	
	A 751	1			schedules will be subject to disciplinary actions. Daily ar	_	
		was a large			weekly monitoring will be ongoing.5. By what date the	<u>.</u>	
	amount of	f dirt and food			systemic changes will be	-	
	particles on top of the				completed? June 23, 2011		
	dish mach	nine.					
	B. There	was adhered					
	dust noted	l on the ceiling					
	in the dish	i room.					
	C Four t	ransportation					
		hauled coffee					
	and water	and other food					
	were stain	ned and dirty.					
	The whee	ls were greasy					
	and dirty.						
	and antry.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		NSTRUCTION 00	(X3) DATE		
			B. WIN	G		05/11/2	011
NAME OF I	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE PLEY STREET		
LAKE PA	RK RESIDENTIAL	CARE INC			TATION, IN46405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	D. The w	hite PVC pipes					
	under the	three					
	compartm	ent sink were					
	dirty with	dried food					
	noted on t	them. The					
	white wal	l underneath					
	the three o	compartment					
	sink was f	food stained.					
	E. There	was adhered					
	dirt and di	ust noted					
	against the	e baseboard					
	under the	three					
	compartm	ent and food					
	prep sinks	S.					
	F. The tw	o trash barrels					
	were dirty	<i>T</i> .					
	G. The si	des of the food					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPLE		
THIS TELLY	or condition	BENTH TOTAL	A. BUII B. WIN			05/11/20	
NAME OF I	PROVIDER OR SUPPLIER		D. WILL		ADDRESS, CITY, STATE, ZIP CODE		
				1	IPLEY STREET		
	RK RESIDENTIAL (STATION, IN46405		715
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE .	DATE
	prep coun	ter and on the					
	back side						
	equipmen	t were dirty					
	with a hea	ıvy					
	accumulat	tion of grease,					
	dust and d	lirt. The silver					
	coils were	also dusty and					
	greasy.						
	H. There	was a large					
	amount of	f food crumbs					
	and dirt ui	nder the food					
	prep table						
	_						
	I. The top	and bottom of					
	the conve	ction ovens					
	_	and greasy.					
	There was	s burned food					
	noted und	er the wire					
	Tacks insid	de the ovens.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING B. WING	CONSTRUC 00	CTION	(X3) DATE COMPI 05/11/2	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY STREET LAKE STATION, IN46405					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION DATE	
		all by the n oven was food spillage						
	noted.	1 , 1						
	grease not	was dust and ted on the sides we and behind						
	•	iddle was d dirty on the on the back						
	that time,	with the ood Manager at indicated all of was in need of						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
111,212,111	or condition.	22.11.10.11.10.11.10.11.22.11.	A. BUILDING B. WING		05/11/2011	
	ROVIDER OR SUPPLIER		STREET 2075 F	ADDRESS, CITY, STATE, ZIP CODE RIPLEY STREET STATION, IN46405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPI	X5) LETION TE
R0214	(a) An evaluation of each resident shall admission and sha semiannually and change in the reside licensed nurse shaneeds of the reside Based on and interv facility fair an evaluate resident's updated at semiannual residents if of 11 who for semi-are	record review iew, the iled to ensure tion of the needs was t least ally for 1 of 11 in the sample were reviewed	R0214	Deficiency #: R214Residents Affected: #11. What corrective action (s) will be accomplished those residents found to have been affected by the deficient practice? Resident #1 has be evaluated and a semi annual assessment was completed during survey. 2. How will the facility identify other resident having the potential to be affected by the same deficient practice and what corrective actions where taken? All residents have potential to be affected by the alleged deficient practice. All residents are being evaluated due assessments will be completed. 3. What means will be put into place or what systemic changes the facility make to ensure that the deficient practice does not recur? Nurses will be re in-serviced on completing semi annual assessments with the deficient practice does not recur? Nurses will be re in-serviced on completing semi annual assessments with the deficient practice does not recurs as a semi annual assessments with the deficient practice does not recurs as a semi annual assessments with the deficient practice does not recurs as a semi annual assessments with the deficient practice does not recurs annual assessments with the deficient practice does not recurs annual assessments with the deficient practice does not recurs annual assessments with the deficient practice does not recurs annual assessments with the deficient practice does not recurs annual assessments with the deficient practice does not recurs annual assessments with the deficient practice does not recurs annual assessments with the deficient practice does not recurs annual assessments with the deficient practice does not recurs annual assessments with the deficient practice does not recurs annual assessments with the deficient practice does not recurs annual assessments with the deficient practice does not recurs annual assessments with the deficient practice does not recurs annual assessments with the deficient practice does not recurs annual assessments with the deficient practice does not recurs annual assessments with the defic	e ed for ed for ed t een es ected e evill et the s ed and eres will eient en	3/2011
	Findings include:			due. A new policy will be insi on completion of semi annua assessments and nursing sta will review.4. How the correct actions will be monitored to	l aff	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
THIS TELLY	or condition	DENTIL CATION NOMBER.	A. BUI B. WIN	LDING JG		05/11/2	
NAME OF F	PROVIDER OR SUPPLIER		D. WII.		ADDRESS, CITY, STATE, ZIP CODE		
	.RK RESIDENTIAL (IPLEY STREET STATION, IN46405		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	JΈ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	ensure the deficient practice	will	DATE
		d for Resident			not recur?The Director of Nu		
	#4 was reviewed on				or designee will provide a schedule of due assessmen		
	5/9/11 at 1	12:10 p.m. The			and will check off completed assessments on a monthly	d	
	resident w	vas admitted to			basis.5. By what date the systemic changes will be completed? June 23, 2011		
	the facility	y on 7/11/08.			completed? June 23, 2011		
	The resident's diagnoses included, but were not						
	limited to	, diabetes					
	mellitus, g	glaucoma,					
	depressive	e disorder,					
	lymphoma	a, high blood					
	pressure, a	and					
	neuropath	y.					
	The reside	ent's semi					
	annual eva	aluations were					
	reviewed	The most					
	recent sen						
	evaluation	n was					
	completed	l on 10/19/10.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/11/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY STREET LAKE STATION, IN46405					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	There wer	re no semi						
	annual eva	aluations						
	available a	after 10/19/10.						
	When inte	erviewed on						
	5/10/11 at 1:45 p.m., the							
	facility Ac	lministrator						
	indicated	the semi						
	annual eva	aluations						
	should have	ve been done						
	every six	months.						
R0215	shall provide the b initial evaluation. S shall compare the his or her status or used to assure that requires is within t	ion evaluation (interview) aseline information for the Subsequent evaluations resident's current status to a admission and shall be at the care the resident the range of personal care sovided by a residential care						
	Based on	record review	R0215	Deficiency #: R215Resident Affected: #61. What correcti	ve			
	and interv	iew, the		action (s) will be accomplish those residents found to have	re			
facility failed to ensure a				been affected by the deficient practice? Pre-admissison	nt			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN			05/11/2	011
NAME OF 1	PROVIDER OR SUPPLIE	R	•	1	ADDRESS, CITY, STATE, ZIP CODE	•	
IAKEDA	RK RESIDENTIAL	CARE INC		1	IPLEY STREET STATION, IN46405		
					ranon, in40405		(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	preadmission evaluation				evaluation has been comple for Resident # 62. How will t		
	was comp	oleted for 1			facility identify other residen having the potential to be aff		
	resident in	n the sample of			by the same deficient practions and what corrective actions		
	11. (Resid	dent #6)			be taken? All residents have		
	11. (100510	dent noj			potential to be affected by the alleged deficient practice. Pr		
					admissions evaluations have		
	Finding in	ncludes:			been completed for all reside in the facility.3. What measu		
					will be put into place or what	t	
					systemic changes the facility make to ensure that the defi		
	The recor	d for Resident			practice does not recur? Nu	rsing	
	#6 was re	eviewed on		review new form insti admission screening. admission Nurse des	and Administrative Assistant review new form instituted for		
	5/9/11 at	9:30 a.m. The			admission screening.Pre admission Nurse designee a Administrative Assistant will	ınd	
	resident v	vas admitted to			be in-serviced on completin preadmission evaluation price	-	
	the facilit	y on 1/8/11.			resident admission.4. How the corrective actions will be		
	The resid	ent had			monitored to ensure the defi practice will not recur?The	cient	
	diagnoses	s that included,			Director of Nursing or design will maintain a check list rec		
	but were	not limited to,			all admissions to the facility		
	diabetes,	,			ensuring that the preadmiss evaluation requirement is mo		
	1				prior to all admissions. Moni	-	
	retardation and schizophrenia with auditory hallucinations.				will be ongoing.5. By what d the systemic changes will be		
					completed? June 23, 2011		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	ILTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL		
			A. BUIL B. WINC			05/11/20	
NAME OF P	ROVIDER OR SUPPLIER		'		DDRESS, CITY, STATE, ZIP CODE		
LAKE PA	RK RESIDENTIAL (CARE INC			PLEY STREET TATION, IN46405		
(X4) ID		TATEMENT OF DEFICIENCIES	\top	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
	There was	no					
	preadmiss	ion evaluation					
	completed	l for the					
	resident.						
	Interview	with the					
	Administr	ator on 5/10/11					
	at 2:45 p.r	n., indicated					
	there had	been no					
	preadmiss	ion evaluation					
	completed	for the					
	resident.						
R0216	shall be delineated manual, but at a massessment shall in following: (1) The resident 's mental status. (2) The resident 's activities of daily live (3) The resident 's and semiannually (4) If applicable, the self-administer me	s physical, cognitive, and s independence in the ving. s weight taken on admission thereafter. e resident 's ability to dications. shall be documented in					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	IDENTIFICATION NOVIDER.	1	LDING		05/11/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	2			IPLEY STREET		
LAKE PA	RK RESIDENTIAL	CARE INC		LAKE S	STATION, IN46405		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG			R)216	Deficiency #: R216Resident	s	06/23/2011
	Based on	record review		v	Affected: # 16, #141. What		
	and interview, the				corrective action (s) will be accomplished for those residuals.	dents	
	facility far	iled to ensure			found to have been affected the deficient practice? Resident		
	an evaluat	tion to			16 no longer resides in the facility.Resident # 14 has be	en l	
					re-assessed for self medical	ation	
	self-admii				administration2. How will the facility identify other residen		
	medicatio	ns was			having the potential to be af by the same deficient practic	fected	
	completed	d for 1 of 2			ce will		
	residents				be taken? All residents in the facility have a potential to be		
					affected. All residents in the		
	self-admii				facility meeting self administ of medication criteria will	tration	
	medicatio	ns in the			be assessed.3. What measu will be put into place or what		
	sample of	11 (Resident			systemic changes the facility make to ensure that the defi	y will	
	#16) and 1	1 of 13			practice does not recur?Nurses are being in	OGTIL	
	residents i	in the			-serviced on assessing		
	suppleme	ntal sample of			residents for self administrations. Nursing staff w	/ill	
	* *	•			then complete self administr form and place on clinical re		
	13 (Resid	em #14).			The self administration polic		
					be reviewed by nursing staff.4. How the corrective a	ctions	
	 Findings i	include:			will be monitored to ensure		
	Findings include:				deficient practice will not recur?The Director of Nursir	ng or	
					designee will maintain a che	eck list	
	1. The clo	sed record for			record of all residents deem capable of self administratio		
	Resident #	#16 was			meds and will monitor		
	IXOSIUCIII †	710 was			ongoing.5. By what date the systemic changes will be		
					Systemia changes will be		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 05/11/2	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY STREET LAKE STATION, IN46405				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	reviewed	on 5/9/11 at			completed? June 23, 2011		
	2:00 p.m. The resident						
	had diagn	oses that					
	included,	but were not					
	limited to	, insulin					
	dependent	t diabetes and					
	hypertension.						
	The Janua	ary 2011					
	Physician	Order Sheet					
	indicated	the resident					
	was to rec	eive 70 units					
	of Lantus	insulin twice					
	daily.						
	Review of	f the forms					
	titled "Glu	acometer and					
	Insulin Re	eading Form"					
		the resident					
		nistered his					
		11500100 1115					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	l` ′	TE SURVEY IPLETED /2011
		STREET 2075 F	RIPLEY STREET	ODE	
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETION DATE
insulin fro	om 10/17/10				
through 1	/10/11.				
The policy	y titled				
"Preparati	on for				
Medicatio	n				
Administr	ration" was				
provided by the					
Administr	rator on 5/10/11				
at 12:00 p	.m. She				
indicated	the policy was				
current. T	he policy				
indicated:					
"If the res	ident desires to				
self-admii	nister				
medicatio	ns, an				
assessmer	nt is conducted				
by the inte	erdisciplinary				
team of th	e resident's				
cognitive,	physical, and				
	PROVIDER OR SUPPLIER SUMMARY'S (EACH DEFICIEN REGULATORY OR insulin from through 1) The policy "Preparati Medication Administry provided 1 Administry at 12:00 provided 1 Administry at 12	i i	DENOTIFICATION NUMBER: A BUILDING B. WING PROVIDER OR SUPPLIER RK RESIDENTIAL CARE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Insulin from 10/17/10 through 1/10/11. The policy titled "Preparation for Medication Administration" was provided by the Administrator on 5/10/11 at 12:00 p.m. She indicated the policy was current. The policy indicated: "If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's	OF CORRECTION DENTIFICATION NUMBER: A BUILDING	DENTIFICATION NUMBER: A BUILDING B WING STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY STREET LAKE STATION, IN46405 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) insulin from 10/17/10 through 1/10/11. The policy titled "Preparation for Medication Administration" was provided by the Administrator on 5/10/11 at 12:00 p.m. She indicated the policy was current. The policy indicated: "If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
			A. BUILDING B. WING		05/11/2011		
NAME OF I	PROVIDER OR SUPPLIER			FADDRESS, CITY, STATE, ZIP CODE RIPLEY STREET	•		
LAKE PA	RK RESIDENTIAL	CARE INC	I	STATION, IN46405			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG	``	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE DATE		
	visual abil	lity to carry out					
	this responsibility,						
	during the	care planning					
	process."						
	•						
	Review of	f the resident's					
	record ind	licated there					
	 was no as						
	completed						
	resident's						
		•					
	sen-aamn	nister insulin.					
	Interview	with the					
	Administr	rator on 5/10/11					
	at 2:45 p.1	n., indicated					
	there had	not been an					
	assessmer	nt of the					
	resident's	ability to					
		nister insulin.					
	SOII adiiiii	moter mounn.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			ULTIPLE CO LDING IG	NSTRUCTION 00	(X3) DATE COMPI 05/11/2	LETED
NAME OF I	PROVIDER OR SUPPLIER	•	1	DDRESS, CITY, STATE, ZIP CODE PLEY STREET	•	
LAKE PA	RK RESIDENTIAL CARE INC		1	TATION, IN46405		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
	2. On 5/9/11 at 1:15					
	p.m., Resident #14 was					
	observed receiving her					
	medications at the					
	nurse's station.					
	LPN #1 asked the					
	resident if she had					
	completed her nebulizer					
	treatment. The resident					
	indicated she had					
	completed the nebulizer					
	treatment.					
	Review of the May 2011					
	Medication					
	Administration Record					
	for Resident #14 on					
	5/9/11 at 1:30 p.m.,					
	indicated a physician's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILE	DING	NSTRUCTION 00	(X3) DATE COMPI 05/11/2	LETED	
	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE PLEY STREET TATION, IN46405	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	order for						
	Ipratropiu	m/Albuterol					
	inhalation	solution, use 1					
	vial per no	ebulizer four					
	times dail	y. The					
	medicatio	n					
	administra						
	had an "S	" documented					
	four times	s per day, May					
	1 through	May 9, 2011.					
	#14's reco 2:00 p.m. resident h that include not limited	f the Resident ord on 5/9/11 at indicated the ad diagnoses ded, but were d to, chronic re pulmonary					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPI		
			B. WIN	IG		05/11/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE PLEY STREET		
LAKE PA	RK RESIDENTIAL	CARE INC		LAKE S	TATION, IN46405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	Review of	f the 2011					
	April Med	lication					
	Administr	ration Record					
	indicated	a "S" was					
	document	ed four times					
	per day fo	or the nebulizer					
	treatment from April 1						
	through A	pril 30.					
	Interview	with RN #1 on					
	5/10/11 at	: 11:15 a.m.,					
	indicated	the "S" means					
	that the re	sident self					
	administe	rs the					
	medicatio	n.					
	A form tit	led,					
	"Medicati	on Self					
	Administr	ation					
	Assessme	nt" that was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN B. WING		00	(X3) DATE S COMPL 05/11/20	ETED	
	PROVIDER OR SUPPLIER		S ²	075 RII	DDRESS, CITY, STATE, ZIP CODE PLEY STREET TATION, IN46405	l	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	dated 11/1	12/07 was in					
	the reside	nt's record. It					
	indicated	the resident is					
	"forgetful	-confusion at					
	times note	ed." There was					
	no current	t assessment of					
	the reside						
	self administer						
	medicatio	ns.					
	The reside	ent's Service					
	Plan, date	d 5/5/11,					
	indicated,	"Staff to					
	administe	r medications					
	to residen	t."					
	Interview	with the					
	Administr	rator on 5/10/11					
	at 2:45 p.1	m., indicated					
	there was	no current					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CO		(X3) DATE	
OF CORRECTION	IDENTIFICATION NUMBER.	1	ING			
					03/11/2	011
PROVIDER OR SUPPLIER						
RK RESIDENTIAL (CARE INC					
				PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
`					TE	DATE
			-			
resident's	ability to					
self-admir	nister					
medication	n.					
provision of reside as ordered by the shall be supervised premises or on cal (1) Medication shallicensed nursing predication aides. Based on record revision facilitity failed the emonittioring and supadministriattion of nursing care as orderelattied the insulin the titing dministriation or dered lab specime pressure for 6 of 11 reviewed for following (Residents #2, #3, #4). Findings include: 1. The record for Residents for the record for Residents #2, #3, #4. Findings include: 1. The record for Residents for the record for Residents #2, #3, #4. Findings include:	Intial nursing care shall be resident 's physician and d by a licensed nurse on the ll as follows: all be administered by ersonnel or qualified View and inttierviewttihe insure a licensed nurse was pervising ttihe insure a licensed nurse was pervising ttihe insure a licensed nurse was pervising tithe insure and monittioring blood insure a sampled residenttis in physician orders. 4, #5, #6, & #17) esident #2 was reviewed on insure a licensed nurse was pervised on insure a licensed nurse was pervised in the licensed nurse was pervised nurse was pervised in the licensed nurse was pervised nurse was pervised nurse was p	R024	41	Affected: # 2, #3, #4, #5, #6, #171. What corrective action will be accomplished for thos residents found to have been affected by the deficient prace. Resident # 2's blood sugar monitoring order has been clarified with the physician. Resident #4's physician. Resident #4's physician was discontinued. Resident #4's blood sugar monitoring orders have been verified with the physician. Physician has been notified orders have been obtained for blood pressure monitoring. Resident's blood pressure has been obtained and recorded. Resident #3's specified with resure layed to physician has been notified. Resident #6 regular	and (s) se n ctice? ician d. and or as imen lts	06/23/2011
	PROVIDER OR SUPPLIER REK RESIDENTIAL OF SUMMARY'S (EACH DEFICIENT REGULATORY OR ASSESSMET) RESIDENT'S SELF-admit MEDICATION (e) The administrat provision of reside as ordered by the shall be supervise premises or on call (1) Medication shall icensed nursing provision aides. Based on record refacilittiy failed this emonitationing and suradministriattion of nursing care as ordered lab specime pressure for 6 of 11 reviewed for following (Residents #2, #3, #4) Findings include: 1. The record for Residents #2, #3, #4 Findings include: 1. The record for Residents #2, #3, #4 Findings include: 1. The record for Residents #2, #3, #4 Findings include:	RECORDECTION IDENTIFICATION NUMBER: PROVIDER OR SUPPLIER REK RESIDENTIAL CARE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) assessment of the resident's ability to self-administer medication. (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident 's physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and inttierviewtihe facilitty failed ttio ensure a licensed nurse was monittioring and supervising ttihe administriattion of medicattions and residenttial nursing care as ordered by ttihe physician relattied ttio insulin administrirattion and glucose ttiestting dministrirattion of Procrittottaining ordered lab specimens and monittioring blood pressure for 6 of 11 sampled residenttis reviewed for following physician orders. (Residents #2, #3, #4, #5, #6, & #17)	DENTIFICATION NUMBER: A. BUILD B. WING PROVIDER OR SUPPLIER RK RESIDENTIAL CARE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) assessment of the resident's ability to self-administer medication. (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and inttierviewtithe facilitty failed ttio ensure a licensed nurse was monittoring and supervising tithe administtirattion of medications and residenttial nursing care as ordered by tithe physician relattied ttio insulin administiration and glucose ttiestting dministtirattion of Procritibitaining ordered lab specimens and monittioring blood pressure for 6 of 11 sampled residenttis reviewed for following physician orders. (Residents #2, #3, #4, #5, #6, & #17) Findings include: 1. The record for Resident #2 was reviewed on 5/9/11 at 10:00 a.m. The resident's diagnoses included but were not limited to, diabetes mellitus. Review of physician orders, dated 12/29/10 and then again on 4/18/11, indicated Novolog Insulin sliding scale twice daily before meals as follows:	PROVIDER OR SUPPLIER RK RESIDENTIAL CARE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ASSESSMENT OF the resident's ability to self-administer medication. (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and inttierviewtthe facilitity failed ttio ensure a licensed nurse was monititoring and supervising tithe administriation of medicattions and residenttial nursing care as ordered by this physician relattied ttio insulin administriation and glucose ttiesttiogdministriation of Procritional physician orders. (Residents #2, #3, #4, #5, #6, & #17) Findings include: 1. The record for Resident #2 was reviewed on 5/9/11 at 10:00 a.m. The resident's diagnoses included but were not limited to, diabetes mellitus. Review of physician orders, dated 12/29/10 and then again on 4/18/11, indicated Novolog Insulin sliding scale twice daily before meals as follows:	PROVIDER OR SUPPLIER RK RESIDENTIAL CARE INC SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MUST BE PERCEDED BY FULL REGILATORY OR LSC IDENTIFYING INFORMATION) ASSESSMENT OF the resident's ability to self-administer medication. (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident 's physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nurse was monittoring and supervising tithe administration of medications and residential nursing care as ordered by the physician relatited tito insulin administration and glucose triesting daministration of Procribibitation of procribibitatio	A BUILDING 9. WING ROVIDER OR SUPPLIER RR RESIDENTIAL CARE INC SIMMARY STATEMENT OF DEFICIENCIES (BACH DEFICENCY MUST BE PERCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) ASSESSMENT OF the resident's ability to self-administer medication. (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident's ry sphysician and shall be supervised by a licensed nurse on the premises or on call as follows: Based on record review and intirerviewtihe facilitity failed the ensure a licensed nurse was monitoring and supervising tithe administration of medications and residential nursing care as ordered by the physician relatited to insulin administration and glucose tresidentis fround to have been affected by the deficient practice? Resident #2's blood sugar monitoring order has been clarified with the physician relation of the complete supervised by a licensed nurse was monitoring order has been clarified with the physician pressure has been obtained for blood pressure monitoring. Resident's plood sugar monitoring orders have been overfied with the physician physician pressure has been obtained for blood pressure main as been notified and orders have been obtained for blood pressure main as been obtained for blood pressure main

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 05/11/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2075 RIPLEY STREET LAKE PARK RESIDENTIAL CARE INC LAKE STATION, IN46405 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE units, 301-350=12 units, and 351-400=15 units. If insulin administration orders have been clarified. Physician has the blood sugar was greater than 400 call the been notified of the administration physician and give 18 units. of wrong doses of Humulin 70/30 on 5/3 and 5/5/2011. Urine CNS Review of physician orders, dated 12/29/10 and was collected and tested then again on 4/18/11, indicated accucheck (finger 05/12/2011 and results relayed to stick blood sugar testing) before meals and at physician. Diet order recorded on bedtime. POS. Resident#5 CMP Lipid Panel HGBA1C was tested and Review of Glucometer and Insulin Reading Form results relaved to physician. for the months of 1/11, 2/11, 3/11, and 4/11 Blood Glucose Meter orders were indicated staff were only documenting an initially obtained 01/31/2011 and accucheck reading at 5:00 a.m., and 5:00 p.m., were not recorded on POS. Blood with the sliding scale coverage. There was no Glucose orders now recorded on documentation of an accucheck completed before POS for May 2011 and forwarded the noon meal or at bed time. to pharmacy. Resident #17 no longer resides in the Review of the Medication Administration Record facility.2. How will the facility (MAR) for the months of 1/11, 2/11, 3/11, and identify other residents having the 4/11 indicated the accucheck before the noon meal potential to be affected by the and at bed time were not recorded as being done. same deficient practice and what corrective actions will be taken? Interview with the LPN #1 on 5/10/11 at 2:45 All residents in the facility have a p.m., indicated she was uanware if the the noon potential to be affected by alleged accucheck and bed time accucheck were being deficient practice. Resident completed. The LPN indicated she had not taken records are being audited for, the resident's accucheck before the noon meal. medication administration, Procrit administration, blood glucose testing, obtaining ordered lab specimens, and monitoring blood pressure .3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? A new form to record blood glucose monitoring will be instituted. Nurses are being in -serviced on blood glucose testing, Procrit administration, medication

administration, obtaining ordered

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/11/2011
	PROVIDER OR SUPPLIER		2075 R	ADDRESS, CITY, STATE, ZIP CODE IPLEY STREET STATION, IN46405	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	reviewed on 5/9/resident's diagnor not limited to, di glaucoma, high blymphoma. The 4/11 Physici indicated there winsulin to be give sliding scale per readings (blood s 11:00 a.m., 4:00 insulin was to be No coverage for or less	r Resident #4 was 11 at 12:10 p.m. The ses included, but were abetes mellitus, blood pressure, and an Order Statement vas an order for Novolog en four times a day per results of glucometer sugar levels) at 7:00 a.m., p.m., and 8:00 p.m. The given as follows: blood glucose levels 150 blog insulin for blood		lab specimens and monitorin blood pressure prior to administering anti hypertens s.4. How the corrective actic will be monitored to ensure deficient practice will not recur?The Director of Nursir designee will perform rando audits of resident records or weekly basis to ensure the compliance with blood gluco testing, Procrit administration medication administration, obtaining ordered lab specin and monitoring blood pressure prior to administering anti-hypertensive's. Monitori will be ongoing.5. By what do the systemic changes will be completed? June 23, 2011	sive' ons the ong or m on a ose on, onens ore

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: LAKE PARK RESIDENTIAL CARE INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFEX (EACH DEPICIENCY MUST BE PERCEDED BY PULL TAG glucose levels 151-170 (S) units of Novolog insulin for blood glucose levels 171-200 (8) units of Novolog insulin for blood glucose levels 201-250 (10) units of Novolog insulin for blood glucose levels 201-350 (12) units of Novolog insulin for blood glucose levels 201-350 (15) units of Novolog insulin for blood glucose levels 201-350 (15) units of Novolog insulin for blood glucose levels greater than 350. There was also an order for the resident to receive an injection of 12 units of Lantus insulin every night at bedtime. The 4/11 "Glucometer and Insulin Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5.35 a.m Blood sugar 263/10 units Novolog insulin given 9:30 p.m Blood sugar 243/8 units Novolog insulin given 15:20 a.m Blood sugar 33/12 units Novolog insulin given 8:45 p.m Blood sugar 33/12 units Novolog insulin given 8:45 p.m Blood sugar 33/12 units Novolog insulin giving insuling insulin giving insuling	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				ULTIPLE CO	ONSTRUCTION	(X3) DATE	
NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC (XA) ID PREFIX (RACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGILATORY OR LSC IDENTIFYING INFORMATION) glucose levels 151-170 (3) units of Novolog insulin for blood glucose levels 201-250 (10) units of Novolog insulin for blood glucose levels 251-300 (12) units of Novolog insulin for blood glucose levels 201-350 (15) units of Novolog insulin for blood glucose levels 201-350 (15) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels greater than 350. There was also an order for the resident to receive an injection of 12 units of Lantus insulin every night at bedtime. The 4/11 "Glucometer and Insulin Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5.35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 263/10 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5.20 a.m Blood sugar 169/5 units Novolog insulin given	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	1	
ACM OF PROVIDER OR SUPPLIES LAKE PARK RESIDENTIAL CARE INC LAKE STATION, INA6405 LAKE ST				B. WIN	_		03/11/2	011
LAKE PARK RESIDENTIAL CARE INC (X0) ID SUMMARY STATEMENT OF DEFICIENCIES TAG RIGGLATORY OR LISC IDENTIFYING INFORMATION) (5) units of Novolog insulin for blood glucose levels 171-200 (8) units of Novolog insulin for blood glucose levels 201-250 (10) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels 201-250 (16) units of Novolog insulin for blood glucose levels 301-350 (17) units of Novolog insulin for blood glucose levels greater than 350. There was also an order for the resident to receive an injection of 12 units of Lantus insulin every night at bedtime. The 4/11 "Glucometer and Insulin Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5:35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 263/10 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given	NAME OF I	PROVIDER OR SUPPLIER			1			
SUMMARY STATEMENT OF DEFICIENCES TAG	I AKE PA	RK RESIDENTIAL (CARE INC		1			
PRETIX TAG REGULATORY OR LISC IDENTIFYING INFORMATION DATE glucose levels 151-170 (5) units of Novolog insulin for blood glucose levels 201-250 (10) units of Novolog insulin for blood glucose levels 251-300 (12) units of Novolog insulin for blood glucose levels 251-300 (13) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels an injection of 12 units of Lantus insulin every night at bedtime. The 4/11 "Glucometer and Insulin Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5:35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 243/8 units Novolog insulin given 7:20 a.m Blood sugar 169/5 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted.		_				171711014, 11440400		aus)
glucose levels 151-170 (S) units of Novolog insulin for blood glucose levels 201-250 (10) units of Novolog insulin for blood glucose levels 201-250 (10) units of Novolog insulin for blood glucose levels 251-300 (12) units of Novolog insulin for blood glucose levels 251-300 (13) units of Novolog insulin for blood glucose levels 251-300 (15) units of Novolog insulin for blood glucose levels greater than 350. There was also an order for the resident to receive an injection of 12 units of Lantus insulin every night at bedtime. The 4/11 "Glucometer and Insulin Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5:35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 243/8 units Novolog insulin given 7:00 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given								l ' '
(5) units of Novolog insulin for blood glucose levels 171-200 (8) units of Novolog insulin for blood glucose levels 201-250 (10) units of Novolog insulin for blood glucose levels 251-300 (12) units of Novolog insulin for blood glucose levels 231-350 (15) units of Novolog insulin for blood glucose levels greater than 350. There was also an order for the resident to receive an injection of 12 units of Lantus insulin every night at bedtime. The 4/11 "Glucometer and Insulin Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5:35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 263/10 units Novolog insulin given 9:30 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given						CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
(5) units of Novolog insulin for blood glucose levels 171-200 (8) units of Novolog insulin for blood glucose levels 201-250 (10) units of Novolog insulin for blood glucose levels 251-300 (12) units of Novolog insulin for blood glucose levels 231-350 (15) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels greater than 350. There was also an order for the resident to receive an injection of 12 units of Lantus insulin every night at bedtime. The 4/11 "Glucometer and Insulin Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5:35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 263/10 units Novolog insulin given 9:30 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given		glucose levels 15	51-170					
glucose levels 171-200 (8) units of Novolog insulin for blood glucose levels 201-250 (10) units of Novolog insulin for blood glucose levels 251-300 (12) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels greater than 350. There was also an order for the resident to receive an injection of 12 units of Lantus insulin every night at bedtime. The 4/11 "Glucometer and Insulin Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5:35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 263/10 units Novolog insulin given 9:30 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given		~						
(8) units of Novolog insulin for blood glucose levels 201-250 (10) units of Novolog insulin for blood glucose levels 251-300 (12) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels greater than 350. There was also an order for the resident to receive an injection of 12 units of Lantus insulin every night at bedtime. The 4/11 "Glucometer and Insulin Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5:35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 263/10 units Novolog insulin given 9:30 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given		1 ' '	-					
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glucose levels 301-350 (15) units of Novolog insulin for blood glucose levels greater than 350. There was also an order for the resident to receive an injection of 12 units of Lantus insulin every night at bedtime. The 4/11 "Glucometer and Insulin Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5:35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 263/10 units Novolog insulin given 9:30 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given		glucose levels 25	51-300					
(15) units of Novolog insulin for blood glucose levels greater than 350. There was also an order for the resident to receive an injection of 12 units of Lantus insulin every night at bedtime. The 4/11 "Glucometer and Insulin Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5:35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 263/10 units Novolog insulin given 9:30 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given		(12) units of Nov	olog insulin for blood					
glucose levels greater than 350. There was also an order for the resident to receive an injection of 12 units of Lantus insulin every night at bedtime. The 4/11 "Glucometer and Insulin Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5:35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 263/10 units Novolog insulin given 9:30 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given		glucose levels 30	01-350					
There was also an order for the resident to receive an injection of 12 units of Lantus insulin every night at bedtime. The 4/11 "Glucometer and Insulin Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5:35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 263/10 units Novolog insulin given 9:30 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given		(15) units of Nov	olog insulin for blood					
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The 4/11 "Glucometer and Insulin Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5:35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 263/10 units Novolog insulin given 9:30 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given		1						
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Reading Form" was reviewed. Glucometer (blood sugar) readings and insulin coverage was recorded as follows: 4/8/11 5:35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 263/10 units Novolog insulin given 9:30 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given								
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4/8/11 5:35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 263/10 units Novolog insulin given 9:30 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given		,						
5:35 a.m Blood sugar 262/10 units Novolog insulin given 4:30 p.m Blood sugar 263/10 units Novolog insulin given 9:30 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given		1	was recorded as follows:					
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4:30 p.m Blood sugar 263/10 units Novolog insulin given 9:30 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given			•					
Novolog insulin given 9:30 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given		_	_					
9:30 p.m Blood sugar 243/8 units Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given		1 ^	•					
Novolog insulin given There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given			_					
There was no 11:00 a.m. blood sugar or insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given		_						
insulin coverage noted. 4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given		_	_					
4/10/11 5:20 a.m Blood sugar 169/5 units Novolog insulin given			C					
5:20 a.m Blood sugar 169/5 units Novolog insulin given								
5:20 a.m Blood sugar 169/5 units Novolog insulin given		4/10/11						
Novolog insulin given			sugar 169/5 units					
			_					
			_					
Novolog insulin given		_	_					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPI	
			B. WIN			05/11/2	U11
NAME OF I	PROVIDER OR SUPPLIEI	R		1	DDRESS, CITY, STATE, ZIP CODE		
	DI DECIDENTIAL	0.455.140			PLEY STREET		
LAKE PA	ARK RESIDENTIAL	CARE INC		LAKES	TATION, IN46405		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		:00 a.m. or 4:00 p.m.					
	blood sugar or in	nsulin coverage noted.					
	4/15/11						
		d sugar 83/ no Novolog					
	insulin given						
		od sugar 281/10 units of					
	Novolog insulin	_					
	4:45 p.m Blood	d sugar 375/15 units of					
	Novolog insulin	given					
	There was no 8:0	00 p.m. blood sugar or					
	insulin coverage	noted.					
	4/17/11						
	5:40 a.m Blood	d sugar 204/8 units of					
	Novolog insulin	given					
	11:00 a.m Bloo	od sugar 322/12 units of					
	Novolog insulin	_					
	1	d sugar 368/15 units of					
	Novolog insulin	_					
	1	00 p.m. blood sugar or					
	insulin coverage						
	4/19/11						
		d sugar 119/no Novolog					
	1	d- Blood sugar 315/12					
		•					
	1	•					
		_					
	4/20/11						
		d sugar 225/8 units of					
		_					
	units of Novolog There were no o insulin coverage 4/20/11	ther blood sugars of noted. d sugar 225/8 units of					

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Event ID: IFZP11

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PRINTED: 06/03/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	00	COMPI 05/11/2	LETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/11/2	
NAME OF I	PROVIDER OR SUPPLIE	R		1	PLEY STREET		
LAKE PA	RK RESIDENTIAL	CARE INC		1	TATION, IN46405		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFECT.)		DATE
	Novolog insulin	od sugar 355/15 units of					
	1	d sugar 325/12 units of					
	Novolog insulin						
	1	00 p.m. blood sugar or					
	insulin coverage						
	msum coverage	nowu.					
	4/22/11						
		d sugar 196/5 units of					
	Novolog insulin						
	T -	d sugar 186/5 units of					
	Novolog insulin	_					
		d sugar 281/10 units of					
	Novolog insulin	_					
	_	:00 a.m. blood sugar or					
	insulin coverage						
	4/23/11						
	5:30 a.m Blood	d sugar 122/no Novolog					
	insulin given						
	5:00 p.m Blood	d sugar 309/12 units of					
	Novolog insulin	given					
	9:00 p.m Blood	d sugar 165/ no Novolog					
	insulin given						
	There was no 11	:00 a.m. blood sugar or					
	insulin coverage	given.					
		dministtirattio s/40 att 1 :45					
		ucomettiers and insulin					
		nould have been done as					
	ordered by ttiheMI)					
	Davious of the 5	/11 Dhysioign Order					
		/11 Physician Order ated there was an order for					
	Statement indica	ned there was an order for					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED	
			B. WING			05/11/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIE	R			PLEY STREET		
I AKE PA	ARK RESIDENTIAL	CARE INC			STATION, IN46405		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFTY (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
IAG	 	<u> </u>	-	TAG	DLI ICILIACI)		DATE
	the resident to re	*					
		eat low blood counts)					
	10,000 units inje	ection weekly on Fridays.					
	The Physician C	Order Statement indicated					
	the medication v	was originally ordered on					
	11/26/10.						
	The 1/11 2/11	3/11, and 4/11 Medication					
	1	Records were reviewed.					
		dication Administration					
	1	it injection was circled as					
	1	/11 and 1/28/11. The					
	1/14/11 and 1/2	1/11 entries were blank.					
	There was no do	ocumentation on the back					
	of the 1/11 Medi	ication Administration					
	Record indicating	g the reason the					
	1	not given or not signed					
	out as given.	not given of not signed					
	out as given.						
	The 2/11 Medie	ation Administration					
		ation Administration					
		d the Procrit injection was					
	1 -	s given on any days					
	throughout the e	entire month. There was					
	no documentation	on on the back of the 2/11					
	Medication Adm	ninistration Record					
	indicating the re	ason the medication was					
	not signed out as						
	list signed out the	- B 					
	The 2/11 Media	ation Administration					
		d the Procrit injection was					
	1	ven on 3/11/11, 3/18/11,					
	and 3/25/11. Th	iere was no					
	documentation of	on the back of the 3/11					
	Medication Adm	ninistration Record					

I ′			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN	IG		05/11/2	U11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
				1	IPLEY STREET		
LAKE PA	RK RESIDENTIAL (CARE INC		LAKES	STATION, IN46405		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	ı	ason the medication was					
	not given.						
		tion Administration					
		I the Procrit injection was					
	ı	ven on 4/1/11 and					
	4/15/11. The 4/8	3/11, 4/22/11, and					
	4/29/11 doses we	ere blank. There was no					
	documentation of	n the back of the 4/11					
	Medication Adm	inistration Record					
	indicating the rea	ason the medication was					
	not given or not	signed out as given.					
	Inttierview wittih Ph	narmacistti5 /1 0/11 atti					
	10:50 a.m., indicatti	ied one dose of Procritti was					
	lastti sentti dı1./26/1	10. The Pharmacistti					
	indicattied prior ttio	ttihat ti1/8 ttiwo doses					
	were senttion 10/29	one dose was senttion					
	10/20 one dose was	s sentțion 10/14 one dose					
	was senttiand on 9/	16 one dose was sentti					
	Seven doses were se	entti sinc⊕/16/10 and					
	ttihe residentti shou	ıld have been getting itti					
	every Friday.						
		p.m., ttihere were four					
		oserved in ttihe medicattion					
	refrigerattior						
	Interview with I DN	#1 on 5/10/11 at 1:45 p.m.,					
		nt should have been receiving					
		eek as ordered by the physician.					
		rder for the resident to receive					
	· ·	_					
	There was also an or Nifediac CC (a med pressure) 30 milligra						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
						05/11/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIER	-					
	DIA DEGIDENTIAL			l	IPLEY STREET		
LAKE PA	RK RESIDENTIAL (CARE INC		LAKES	STATION, IN46405		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	CC was to be held it	f the resident's systolic (top					
	number) blood press	sure reading was less then 120.					
	•						
	The 1/11, 2/11, 3/11	, and 4/11 Medication					
	Administration Reco	ords were reviewed. The					
	Nifediac CC medica	ation was signed out as given at					
		ough 2/22/11. There was no					
		e resident's blood pressure					
	reading prior to the	medication being given. The					
	Nifediac CC medica	tion was signed out as given					
	3/1/11 through 3/31/	/11 at 9:00 p.m. There was no					
	documentation of th	e resident's blood pressure					
		ninistering the medication. The					
		gned out as given 4/2/11					
	1 -	2:00 p.m. There was no					
		e resident's blood pressure					
	reading prior to adm	ninistering the medication.					
		desident #3 was reviewed on					
		The resident's diagnoses					
		not limited to, diabetes					
		nal failure, and asthma. There					
	1	ders written on 10/25/10 and					
	_	becimens to be collected for					
	C-Diff (an infection)) and sent to the laboratory.					
	Review of the labor	atory test results section of the					
		cord indicated there was no					
		sults of any stool specimens					
	for C-Diff from 10/1						
	23. 3 2.11 110111 10/1	Jugar varione.					
	When interviewed o	on 5/10/11 at 1:45 p.m., the					
		or indicated there were no					
	1	om the stool specimens as the					
	specimens were not						
	4. The record for	Resident #6 was					
		11 at 9:30 a.m. The					
		nitted to the facility on					
	1/8/11. The resid	ent had diagnoses that					

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Facility ID:

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I '			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN			05/11/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	DI DECIDENTIAL	CARE INC		1	PLEY STREET		
	RK RESIDENTIAL (LAKE S	TATION, IN46405		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		,	+	IAG	Dia relative 17		DATE
	included, but we	,					
	diabetes, mental						
	schizophrenia wi	ith auditory					
	hallucinations.						
	Th	aiaianla andan data 10/1/11					
		sician's order dated 3/1/11					
		30 Insulin to be given					
	twice daily.						
	On 4/25/11 41	roaldont reas 1 41.					
	l '	resident was seen by the					
	1 ^ ^	hysician indicated the					
		lin dependent diabetes.					
		mpression indicated,					
		sulin dependent diabetes."					
		dered check blood sugar					
		and adjust insulin. On					
		as a physician's order for					
		er sliding scale as					
	follows:						
	150-200 5 units						
	201-250 10 units	ł					
	251-300 15 units						
	above 300 call do	octor					
		"Glucometer and Insulin					
	Reading Form" v	vere reviewed. The forms					
	indicated the date	e and times of the					
	glucometers and	the amount of Insulin					
	administered:						
	4/26/11 6:20 a.m	. Glucometer 261 10					
	units Humulin 70	0/30					
	4/26/11 (no time	indicated) Glucometer					
	247 10 units Hu	mulin 70/30					
	4/29/11 7:00 a.m	. Glucometer 335 10					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTII A. BUILDIN		NSTRUCTION 00	(X3) DATE S	
			B. WING	u		05/11/2	011
	PROVIDER OR SUPPLIER		20	75 RI	DDRESS, CITY, STATE, ZIP CODE PLEY STREET TATION, IN46405		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	· I	PROVIDENCE DE AN OF CONDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREI	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)	MIE.	DATE
	units Humulin 70	0/30		I			
	5/1/11 8:00 a.m.	Glucometer 199 10 units					
	Humulin 70/30						
	5/2/11 6:20 a.m.	Glucometer 250 10 units					
	(no insulin type i	indicated)					
	5/3/11 4:30 a.m.	Glucometer 255 15 units					
	Humulin 70/30						
	5/3/11 (no time i	ndicated) Glucometer					
	291 15 units (no	insulin type indicated)					
	5/4/11 7:45 a.m.	Glucometer 246 10 units					
	Humulin 70/30						
	5/4/11 5:00 p.m.	Glucometer 176 10 units					
	Humulin 70/30						
	5/5/11 6:45 a.m.	Glucometer 221 10 units					
	Humulin 70/30 &	& Novolog regular insulin					
	10 units						
	5/5/11 5:30 p.m.	Glucometer 284 15 units					
	Humulin 70/30						
	5/6/11 6:30 a.m.	Glucometer 162 10 units					
	Humulin 70/30 &	& Novolog regular insulin					
	5 units						
	5/6/11 5:00 p.m.	Glucometer 185 10 units					
	Humulin 70/30						
	5/8/11 7:00 a.m.	Glucometer 275 15 units					
	Novolog regular	insulin					
	5/9/11 6:35 a.m.	Glucometer 294 10 units					
	Novolog 15 units	S					
		cumentation for insulin					
		r glucometer readings for					
		and $5/7/11$. There was					
	_	mentation for twice daily					
		70/30 administration on					
	5/1, 5/2, and 5/8/	2011. There was					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
			B. WING		<u></u>
	PROVIDER OR SUPPLIER		2075 R	address, city, state, zip c RIPLEY STREET STATION, IN46405	ODE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE L DEFICIENCY)	HOULD BE COMPLETION
	incomplete docu meal Regular ins	mentation of the before ulin sliding scale all days, 4/26/11			
	were not obtaine physician. There that the routine d insulin and the sl	readings before meals d as ordered by the was no documentation oses of Humulin 70/30 iding scale doses of were administered as			
	5:30 p.m., 15 uni were administere was no order for	of a.m. and on 5/5/11 at the soft Humulin 70/30 and to the resident. There to units of Humulin mistered to the resident.			
	11:30 a.m., indice the physician's or with sliding scale 2011 Medication indicated the residually glucometer 2011 Medication had not been upon physician's order the glucometer residuals.	MA #1 on 5/10/11 at ated she was unaware of orders for glucometers to before meals. The May Administration Record dent was to receive twice as. She indicated the May Administration Record ated with the current ated with the current to She also indicated that readings had not been red by the physician.			
		N #1 on 5/10/11 at 11:35 ne was not aware of the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DDIC	00	COMPL	ETED
			B. WIN			05/11/2	011
		1	B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			IPLEY STREET		
IAKEDA	RK RESIDENTIAL	CARE INC		1	TATION, IN46405		
LANE FA	TRY RESIDENTIAL	CARE INC		LAKE 3	TATION, IN40405		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	sliding scale ord	er for Regular insulin.					
	She indicated th	at wrong doses of					
	Humulin 70/30	were administered to the					
	resident on 5/3/1	11 and 5/5/11. She					
	indicated that it	appeared the staff used					
		lin sliding scale dose for					
	_	30 instead of the dose					
	ordered by the p						
	ordered by the p	nysician.					
		he Administrator on					
	1	o.m., indicated the staff					
	did not administ	er the resident's insulin as					
	ordered by the p	hysician.					
	Review of the N	May 2011 physician order					
		vas no documentation of					
	the resident's cur						
	the resident's cu	iront diet.					
	There was a phy	rsician's order dated					
		ne culture and sensitivity.					
		ocumentation of the urine					
	culture in the res	sident's record.					
	Interview with the	he Administrator on					
	5/10/11 at 2:45 p	o.m., indicated the record					
	was incomplete.	She indicated the diet					
	_	urrent physician's order					
		lture was not in the					
	record.	icare was not in the					
	iccord.						
	5 Tho 1 C	n Dagidant #5 mag					
		or Resident #5 was					
		/11 at 12:30 p.m. The					
		gnoses that included, but					
	were not limited	to, congestive heart					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING		NSTRUCTION 00	COMPL	ETED	
			B. WING			05/11/2	011
	PROVIDER OR SUPPLIER		20	75 RII	DDRESS, CITY, STATE, ZIP CODE PLEY STREET		
LAKE PA	ARK RESIDENTIAL	CARE INC	LA	KE S	TATION, IN46405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
1110	failure and diabe	<u> </u>					Ditte
	There was a physical laboratory tests to the complete metable and HGBA1C (goto be obtained extended to be obtained to	sician order for routine hat included, CMP olic profile), lipid panel, glycosylated hemoglobin) very 3 months. Review of sts indicated the last time e obtained was 1/12/11. b results for April 2011. rm titled, "Glucometer ling Form" indicated the eving glucometer April and May 2011. oril and May 2011 Sheets indicated there in order for glucometer are Administrator on one.m., indicated there was der for the the the CMP, lipid panel, and not been obtained in the groses that included, but to, mild mental					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI B. WING	DING	00	(X3) DATE S COMPL 05/11/20	ETED
	PROVIDER OR SUPPLIER	CARE INC		2075 RIF	DDRESS, CITY, STATE, ZIP CODE PLEY STREET FATION, IN46405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
R0300	9/20/10, for stool c-dif. There was resident's record results for the sto and c-dif. Interview with th 5/10/11 at 2:45 p was incomplete. laboratory tests for were not in the resident and biologic be labeled in according and biologic be labeled in according and the Based on observating interview, the fact multi dose vials of with the date they residents in the standard are sidents (Residents #2, #11). The facility also multidose vials of the stool of the vials of the vi	er medications, prescription cals used in the facility must rodance with currently onal principles and include cessory and cautionary	R0.	300	Deficiency R300Residents Affected: #2, #3,#4,#6,#7,#8, and #111. What corrective ac (s) will be accomplished for the residents found to have been affected by the deficient prace Resident's #2, #3, #4, #6,#7, #10 and#11 has been discard and replaced with labeled insignate vials. 2. How will the facility identify other residents havin potential to be affected by the same deficient practice and we corrective actions will be take	ction hose tice? #8, ded sulin g the e	06/23/2011

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li '		(X2) MU	(X2) MULTIPLE CONSTRUCTION (X3) DATE S						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	LDING	00	COMPL			
			B. WING			05/11/2	011		
NAME OF	PROVIDER OR SUPPLIEI	<u>u</u>	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF	FROVIDER OR SUPPLIED	Λ		2075 RI	PLEY STREET				
	ARK RESIDENTIAL			L	TATION, IN46405				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	1	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE		
IAG			-	IAG	All residents having insulin		DATE		
	1 ' ' '	pharmacy policy for 3			orders have a potential to be				
	residents in the supplemental sample of 13.				affected by alleged deficient				
		0 1 //10)			practice. All opened insulin v				
	(Residents #7, #	8, and #10).			have been checked for dates				
					opening.3. What measures v put into place or what systen				
	Findings include	:			changes the facility will make				
					ensure that the deficient prac				
	The pharmacy ".	* *			does not recur? Nurses are				
	Recommended Minimum Medication Storage Parameters(based on manufacturer package inserts)" was				being in -serviced on dating				
					discarding of insulin vials. Po regarding discarding insulin v				
					and labeling when opening w				
	reviewed on 5/10/11 at 1:00 p.m. There was no date on the Appendix. The				reviewed with nursing				
					staff.4. How the corrective ac				
	Appendix indica	ated all vials of insulin			will be monitored to ensure t	he			
	products were to	discarded 28 days after		deficient practice will not recur? Director of Nursing					
	opening.								
	The pharmacy p	olicy titled "Preparation		or designee will maintain a received and disposal calendar					
	for Medication A	Administration" was			for all insulin vials. The Dire				
	reviewed on 5/1	0/11 at 1:00 p.m. The			of Nursing and/or designee v				
		1 10/24/2007. The policy			randomly check vials of insul the refrigerator on a weekly be				
	1 * *	nd ampules of injectable			Monitoring will be ongoing.5				
		e to be labeled with the			what date the systemic chan	ges			
	1	the employees initials			will be completed? June 23,	2011			
	1 ^	pened for the first time.							
	On 5/10/11 at 10	0:50 a.m., medications in							
	1	n the Main Nursing							
	1	served. There were 3							
		sulin in the refrigerator							
	1 -	ened longer then 28 days							
	as follows:	1011ger 20 auju							
		rus insulin for Resident #7							
	opened on 3/21/								
		rus insulin for Resident							
	One viai of Lant	us msum for Resident							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
			B. WINC	·		05/11/2	011
NAME OF	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					IPLEY STREET		
LAKE PA	ARK RESIDENTIAL	CARE INC		LAKE S	STATION, IN46405		
(X4) ID	1	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	I '	NCY MUST BE PERCEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	#10 opened on 4						
	1	us insulin for Resident #8					
	opened on 4/2/1						
	One vial of Nov	olin R insulin for					
	Resident #7 open	ned 3/20/11					
	Labels on the above insulin vials						
	indicated they were to be discarded 28						
	days after they were first opened.						
	There were 8 opened vials of insulin						
	stored in the refrigerator that had labels						
	that indicated they were to be discarded						
		ey were first opened. The					
	1 -	e not dated with the date					
	1	pened as follows:					
	1 -	rus insulin for Resident #4					
	1	ntus insulin for Resident					
	#11	itus ilisuilli ioi Residelit					
	1	alia 70/20 fan Daaidant #2					
		olin 70/30 for Resident #3					
		olog insulin for Resident					
	#2						
	1	nulin 70/30 insulin for					
	Resident #6						
	1	olin R insulin for					
	Resident #7						
	One vial of Nov	olin R insulin for					
	Resident #8						
		ed on 5/10/11 at 11:00					
	a.m., RN #2 indi	icated the above residents					
	were currently re	eceiving the insulins					
	listed. The RN i	indicated the insulin vials					
	were to be discar	rded 30 days from the					
	date they were fi	-					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED 05/11/2011
			B. WING	LANDERS STORY STATE OF SORE	03/11/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
LAKE PA	RK RESIDENTIAL (CARE INC		STATION, IN46405	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	p.m., the facility the insulin vials s	d on 5/10/11 at 1:45 Administrator indicated should have been labeled per the pharmacy			
R0349	 (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interviews, the facility failed to ensure the resident records were accessible, accurate and complete related to, follow up assessment after a fall, diet orders, and medications administered as ordered by the physician, for 4 of 11 sampled residents. (Residents #1, #2, #4, and #16) Findings include: 1. On 5/9/11 at 12:30 p.m. and at 2:00 p.m., the closed record for Resident #1 was requested. Interview with Administrator at 2:30 p.m., on 5/9/11 indicated they was not able to locate the 		R0349	Deficiency #: R349Residents Affected: #1, #2, #4 and #161. What corrective action will be accomplished for thos residents found to have beer affected by the deficient practice? Resident #1 no lor resides in facility but facility we continue all efforts to locate closed record for dates reque by surveyors. Resdent#2 wa assessed at the hospital. Resident #4 is currently rece the Miralax and nurses are documenting on the administration. Resident #16 longer resides in the facility.2. How will the facility identify other residents havin potential to be affected by the same deficient practice and we	(s) se n nger vill ested s iving no

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD	DING	OO	(X3) DATE S COMPL 05/11/2	ETED	
	PROVIDER OR SUPPLIER		B. WING	STREET AD	DDRESS, CITY, STATE, ZIP CODE PLEY STREET FATION, IN46405	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤΕ	(X5) COMPLETION DATE
	p.m., and 2:45 p. Resident #1 was with the Administ p.m., indicated the locate the resider. Interview with the 5/11/11 at 8:30 at not able to locate had even called to hursing. 2. The record for reviewed on 5/9/10 of Nurse's Notes the resident had onto the floor in resident indicate there was a burn resident was sen. Nurse's Notes, do indicated the resident was sen. Nurse's Notes, do indicated the resident's condition to the floor in resident was sen. Nurse's Notes, do indicated the resident's condition to the floor in resident was sen.	m., the closed record for requested. Interview strator on 5/10/11 at 3:00 ney still were not able to nt's closed record. The Administrator on m., indicated they were the closed record and the old Director of the old Director of the toilet and her bathroom. The dishe had hit her head and pon her forehead. The to the hospital. The to the hospital. The to the hospital signs to or an assessment of the toilet and the that returned from the toilet and the toilet and they are the total time. Nurse's 4/11 at 4:20 p.m., the total time. Nurse's 4/11 at 4:20 p.m., the total time and they are was no vital signs to or an assessment of the toilet and the that time. Nurse's 4/11 at 4:20 p.m., the total time and they are was no vital signs to or an assessment of the ton at that time. Nurse's 4/11 at 4:20 p.m., the total time and they are the total time. The total time are was no vital signs to or an assessment of the ton at the time. Nurse's 4/11 at 4:20 p.m., the total time and they are the total time. The total time are the total time. The total time are the total time are the total time. The total time are the total time are the total time. The total time are the total time are the total time. The total time are the total time are the total time. The total time are the total time are the total time are the total time. The total time are the total time are the total time are the total time. The total time are the total time are the total time are the total time. The total time are the total time are the total time are the total time. The total time are the total time are the total time are the total time. The total time are the to			corrective actions will be take All residents in the facility had potential to be affected by all deficient practice. All closed records will be placed in a designated area for better accessibility upon request. Resident #2 was hospitalized during survey at was reassessed upon return facility. Resident #4 is currer receiving Miralax as reflected Medication Administration Resident #16 no longer resident #16 no longer resident potential for the facility, but diet order whound in discharged Kardex of Dietary Orders by Dietary Supervisor. 3. What measures be put into place or what systemages the facility will make ensure that the deficient pracedoes not recur? Nurses will be serviced on forwarding closer resident clinical records to Director of Nursing or design recording medication administration or refusal, recording diet orders, and completing fall assessment. 4. How the corrective actions be monitored to ensure the deficient practice will not recordine to ensure the deficient practice will not recordine to practice will not recordine to ensure the deficient practice will not record and accessible by maintaining a log of location closed records. Director of Nursing or Designee will randomly check Medication Administration Record on a weekly basis for proper	ave a leged and to attly din ecord des vas of se will etemic et to etice e in eed enee, se will ur?	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
			B. WING	G		05/11/2	011
NAME OF	PROVIDER OR SUPPLIEI	- {	•	l	ADDRESS, CITY, STATE, ZIP CODE	-	
				l	PLEY STREET		
LAKE PA	ARK RESIDENTIAL	CARE INC		LAKE S	STATION, IN46405		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		
	1 ~	sed temperature and			documentation regarding administration of medication	or	
	complaints of pain. The next documented				refusal of such. Director of	Oi	
	1 -	Notes was on 4/14/11 at			Nursing or designee will follo	w up	
	1 -	n indicated the resident's			on all fall incidents and main	tain	
	1 ^	100.2. There was an			ongoing log. The Director of	-111	
	assessment of th	e resident's head at that			Nursing or designee will che physician order sheets for cu		
	time.				diet orders on a monthly bas		
	Nurse's Notes dated 4/14/11 at 7:15 p.m.,				Monitoring will be ongoing.5.		
					what date the systemic chan		
	indicated the resident was repeatedly				will be completed? June 23,	2011	
	slipping out of her chair. She was then						
	taken back to her room and assisted back						
	to bed by two staff members. The CNA						
	I -	e had to feed the resident					
	her evening mea	l. The resident had upper					
	1	and there was a bruise to					
	1 *	he resident's temperature					
		es. The resident's					
	1	otified and orders to send					
	1	ne hospital were received.					
	1	for the hospital per					
		55 p.m. The resident was					
	1	nospital with a head					
	concussion.						
	Tonicussion.						
	Interview with I	PN #1 on 5/10/11 at 2:00					
	p.m., indicated t						
	1 *	of an assessment done					
		nt returned from the					
		/11 at 2:00 p.m., nor was					
	1 ^	l assessment of the					
	1 .	e had complaints of her					
	1	onau compiantis of tici					
	head hurting.	for Resident #4 was					
	j. The record	ioi resident #4 was					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN			05/11/20	J11
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
	DK DECIDENTIAL	CARE INC		1	IPLEY STREET		
	RK RESIDENTIAL			L	STATION, IN46405		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAU			-	IAG	Dia lettike 1 y		DATE
		11 at 12:10 p.m. The					
	_	ses included, but were					
	not limited to, high blood pressure and diabetes mellitus.						
	diabetes memus.						
	4 D1	1					
	1 -	der was written on					
	3/26/11 for the resident to receive Miralax						
	(a laxative) 17 grams mixed in water						
	daily. Review of the 4/11 Medication						
	Administration Record indicated the						
	medication was only signed out as given						
	· ·	1, and 4/16/11. Entries					
	·	g days were blank.					
		page of the Medication					
		Record indicated there					
		tation related to the					
	Miralax.						
		ed on 5/10/11 at 1:45					
		Administrator indicated					
		on on the Medication					
	Administration I						
	completed as req	juired.					
		cord for Resident #16 was					
		11 at 2:30 p.m. The					
	resident had diag	gnoses that included, but					
	were not limited	to, insulin dependent					
	diabetes and hyp	pertension.					
	Review of the Ja	nuary 2011 physician					
	order indicated to	here was no					
	documentation o	of the resident's diet.					

001136

A. BUILDING	(X5) COMPLETION
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY STREET	(X5)
NAME OF PROVIDER OR SUPPLIER 2075 RIPLEY STREET	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY	
The Redelation of Escillatin The Internation in Internation in the Internation in the Internation in Intern	DATE
Interview with the Administrator on	
5/10/11 at 2:45 p.m. indicated the	
Physician's Order Sheet was incomplete	
and did not include the resident's diet.	
R0378 (b) If the individual is a recipient of Medicaid or federal Supplemental Security Income	
(SSI), the individual needs evaluation	
provided in section 2(a) of this rule shall	
include, but not be limited to, the following:	
(1) Screening of the individual for major	
mental illness, such as a diagnosed major	
mental illness, is limited to the following disorders:	
(A) Schizophrenia.	
(B) Schizoaffective disorder.	
(C) Mood (bipolar and major depressive type)	
disorder.	
(D) Paranoid or delusional disorder. (E) Panic or other severe anxiety disorder.	
(F) Somatoform or paranoid disorder.	
(G) Personality disorder.	
(H) Atypical psychosis or other psychotic	
disorder (not otherwise specified).	
(2) Obtaining a history of treatment received	
by the individual for a major mental illness within the last two (2) years.	
(3) Obtaining a history of individual behavior	
within the last two (2) years that would be	
considered dangerous to facility residents, the	
staff, or the individual.	
Based on record review and interview, the R0378 Deficiency #378Residents	06/23/2011
facility failed to ensure a mental health Affected: #61. What corrective action(s) will be accomplished for	_r
needs evaluation was completed for 1 of 1 those residents found to have	·
residents with mental illness, in the been affected by the deficient	
sample of 11. Resident #6 had a mental health screening done by	,
Finding includes: St. Catherine's Hospital	

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NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC SIRREST ADDRESS, CITY, STATE, ZIP CODE 2075 RPILEY STREET LAKE STATION, IN48405 SUPPLEY STREET LAKE STATION, IN48405 ID PREDIX TAG The record for Resident #6 was reviewed on 5/9/11 at 9:30 a.m. The resident was admitted to the facility on 1/8/11. The resident had diagnoses that included, but were not limited to, mental retardation and schizophrenia with auditory hallucinations. There was no mental health screening and no mental health aceds evaluation completed for the resident. Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated there had been no mental health screening and no mental health organized will be put into place or what systemic changes scilical records are being audited. 3. What measures will be put into place or what systemic changes the facility will be neseroted on ensuring that any resident with a major mental health diagnosis will have a mental health screen completed prior to admission. 4. How the corrective actions will be monitored	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC O(9) ID SUMMARY STATEMENT OF DEFICIENCIES PREFEX (EACH DEFICIENCY MUST BE PERCEDED BY PULL TAG REGULATORY OR RESCIDENTIFIENG INFORMATION) The record for Resident #6 was reviewed on 5:9/11 at 9:30 a.m. The resident was admitted to the facility on 1/8/11. The resident had diagnoses that included, but were not limited to, mental retardation and schizophrenia with auditory hallucinations. There was no mental health screening and no mental health needs evaluation completed for the resident. Interview with the Administrator on 5:10/11 at 2:45 p.m., indicated there had been no mental health screening and no mental h	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
LAKE PARK RESIDENTIAL CARE INC LAKE PARK RESIDENTIAL CARE INC LAKE PARK RESIDENTIAL CARE INC SIMMARY STATEMENT OF DETICIENCIES PREFIX TAG SIMMARY STATEMENT OF DETICIENCIES PREFIX TAG The record for Resident #6 was reviewed on 5/9/11 at 9:30 a.m. The resident was admitted to the facility on 1/8/11. The resident had diagnoses that included, but were not limited to, mental retardation and schizophrenia with auditory hallucinations. There was no mental health screening and no mental health needs evaluation completed for the resident. Interview with the Administrator on 5/10/11 at 2.45 p.m., indicated there had been no mental health screening and no mental health needs evaluation completed for the resident. Interview mental health screening and no mental health needs evaluation completed for the resident. Interview with the Administrator on 5/10/11 at 2.45 p.m., indicated there had been no mental health screening and no mental health screening script mental script mental screening script mental script me				1			05/11/2	011
LAKE PARK RESIDENTIAL CARE INC	NAME OF I	DDOLUDED OD GUDDUIE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
Ox4 ID PREFIX (RACH DEFICIENCY MIST BE PERCEDED BY FULL TAG PREFIX (RACH DEFICIENCY MIST BE PERCEDED BY FULL TAG PREFIX PR	NAME OF	PROVIDER OR SUPPLIER	C		2075 RI	IPLEY STREET		
PREFIX TAG REGULATORY OR LSC DENTIFYING INFORMATION) The record for Resident #6 was reviewed on 5/9/11 at 9:30 a.m. The resident was admitted to the facility on 1/8/11. The resident had diagnoses that included, but were not limited to, mental retardation and schizophrenia with auditory hallucinations. There was no mental health screening and no mental health needs evaluation completed for the resident. Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated there had been no mental health screening and no mental health needs evaluation completed for the resident. Interview with the Administrator on solution of the resident was a mental health needs evaluation completed for the resident. Interview with the Administrator on solution of the resident was a mental health screening and no mental health needs evaluation completed for the resident. Interview with the Administrator on solution of the resident was a mental health screening and no mental health screenin					LAKE S	TATION, IN46405		
TAG REGILATORY OR LSC IDENTIFYING INFORMATION) The record for Resident #6 was reviewed on 5/9/11 at 9:30 a.m. The resident was admitted to the facility on 1/8/11. The resident had diagnoses that included, but were not limited to, mental retardation and schizophrenia with auditory hallucinations. There was no mental health screening and no mental health needs evaluation completed for the resident. There with the Administrator on 5/10/11 at 2:45 p.m., indicated there had been no mental health screening and no mental health needs evaluation completed for the resident. The resident with the weak of the resident in						PROVIDER'S PLAN OF CORRECTION		
The record for Resident #6 was reviewed on 5/9/11 at 9:30 a.m. The resident was admitted to the facility on 1/8/11. The resident had diagnoses that included, but were not limited to, mental retardation and schizophrenia with auditory hallucinations. There was no mental health screening and no mental health heeds evaluation completed for the resident. Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated there had been no mental health screening and no mental health seeds evaluation completed for the resident. Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated there had been no mental health screening and no me						CROSS-REFERENCED TO THE APPROPRIATE	ΤE	
The record for Resident #6 was reviewed on 5/9/11 at 9:30 a.m. The resident was admitted to the facility on 1/8/11. The resident had diagnoses that included, but were not limited to, mental retardation and schizophrenia with auditory hallucinations. There was no mental health screening and no mental health needs evaluation completed for the resident. Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated there had been no mental health screening and no mental health heads evaluation completed for the resident. Interview with the Administrator on 5/10/11 at 2:45 p.m., indicated there had been no mental health screening and no mental health screening section on all a completed for the resident. Interview of the resident with a major mental health screening section on all new admits on team of the facility will be in serviced on ensuring that any resident with a major mental health screen completed prior to admission. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur? The Director of Nursing or designee will complete a preadmission evaluation form which include mental health screening section on all new admits prior to admission to facility. The Administrator or designee will monitor for compliance ongoing 3. By what date the systemic changes will be	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
completed? June 23, 2011	IAU	The record for R on 5/9/11 at 9:30 admitted to the f resident had diag were not limited and schizophren hallucinations. There was no meno mental health completed for th Interview with th 5/10/11 at 2:45 p been no mental health ne	esident #6 was reviewed a.m. The resident was facility on 1/8/11. The gnoses that included, but to, mental retardation ia with auditory ental health screening and needs evaluation e resident. ne Administrator on o.m., indicated there had nealth screening and no		IAU	Behavioral Health on October 2010. Resident#6 also had a mental health screening don February 1, 2011 by Regional Mental Health. A copy has be placed on Reident#6's clinical record. How will the facility identify other residents having potential to be affected by the same deficient practice and corrective actions will be take Residents who have major mental health diagnoses have potential to be affected by the alleged deficient practice. All residents that have major mehalth diagnoses clinical recorder being audited. What measures will be put into pla what systemic changes the fewill make to ensure that the deficient practice does not result that any resident with a major mental health diagnosis will be in serviced on ensuring that any resident with a major mental health diagnosis will a mental health screen comporior to admission. How the corrective actions will be monitored to ensure the deficient practice will not recur? The Director of Nursing or design will complete a preadmission evaluation form which included mental health screening section all new admits prior to admission to facility. The Administrator or designee will monitor for compliance ongoing. By what date the systemic changes will be	e e al een al y g the e what en? ye the e lental ords ce or acility ecur? acility ag or have bleted ene cient ee i e e tion	DATE

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		00	COMPL 05/11/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	03/11/2	011
NAME OF I	PROVIDER OR SUPPLIER				IPLEY STREET		
LAKE PA	RK RESIDENTIAL (CARE INC		1	STATION, IN46405		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
R0407	(b) The facility must control program the (1) A system that is analyze patterns of symptoms. (2) Provides oriented education on infectincluding universal (3) Offering health including, but not litransmission and in (4) Reporting combine alth authorities. Based on crecord revinterviews failed to exproper used disinfecting used during the sample (Resident in the sample (Resident in the sample cresident in the sample cresident in the sample control of the sample cresident in the sample credit the samp	st establish an infection at includes the following: enables the facility to follow infectious ation and in-service tion prevention and control, infection precautions. Information to residents, imited to, infection infection infection infection, included infection i	RO	0407	Deficiency #: R407Residents Affected: #5, and #111. What corrective action (s) will be accomplished for those resid found to have been affected the deficient practice? Resic #5 and #11 Glucometer's we cleaned with a Bleach Wipe nursing staff wearing gloves.2. How will the facility identify other residents havin potential to be affected by the same deficient practice and occorrective actions will be take All residents on Glucometer testing in the facility have a potential to be affected by all deficient practice. All Glucometers have been disinfected with bleach wipes nursing staff wearing gloves.3. What measures will put into place or what system changes the facility will make ensure that the deficient pra does not recur? Nurses will be serviced on the proper clean method of Glucometer using Bleach Wipes as recommend	ents by lent re by g the e what en? eged by I be nic e to ctice pe in ing	06/23/2011

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLI			
ANDILAN	or conduction	IDENTIFICATION NOWIDER.	- 1	LDING	00	05/11/20			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ			
NAME OF I	PROVIDER OR SUPPLIER			2075 RI	IPLEY STREET				
LAKE PA	RK RESIDENTIAL	CARE INC		LAKE S	STATION, IN46405				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION		
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE		
	Findings i	nclude:			by manufacturer. In addition nurses will be in-serviced on				
					cleaning Glucometers weari	ng			
					gloves.4. How will the corrective actions be monitored to ensure				
	QMA #1 was observed				the deficient practice will not				
	on 5/10/11	1 at 11:00 a.m.			recur? Nursing staff will be monitored monthly at randor				
	recording	glucometer		Director of Nursing or designee during blood glucose testing for cleaning of Glucometer and					
	readings f	for the			performance documented.				
	residents.	She gave			Monitoring will be ongoing.5 By what date the systemic changes will be completed? June 23, 2011				
	Resident #	#5 an Assure	Assure will be completed? June 23, 2011						
	Platinum	glucometer.							
	The reside	ent obtained the							
	blood sam	ple and the							
	glucomete	er reading							
	herself. Sl	ne then							
	returned the	he glucometer							
	to the QM	IA. The QMA							
	cleaned th	e glucometer							
	with an is	opropyl							
	alcohol 70	% pad. The							
	QMA was	s not wearing							
	gloves.								

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPI		
		A. BUI B. WIN	LDING IG		05/11/2		
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	P. W.	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
LAKE PARK RESIDENTIAL CARE INC				1	PLEY STREET TATION, IN46405		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
ING	REGUENTORT OR	ESC ISENTIL TINO IN ORGANIZATION		mo	·		DAIL
	 Resident #	#11 then came					
	to the nur	se's station.					
	The QMA	gave the					
	resident a	Liberty					
	glucomete	er. The resident					
	obtained the blood						
	sample an	d the					
	glucomete	er reading and					
	returned the glucometer						
	to the QM	IA. The QMA					
	cleaned the glucometer						
	with an is	opropyl					
	alcohol 70% pad. She						
	was not wearing gloves.						
	Interview	with the QMA					
	on 5/10/11	1 at 11:15 a.m.,					
	indicated	each resident					
	has their o	own					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE S COMPL 05/11/2	ETED	
NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC			ST 20	75 RI	DDRESS, CITY, STATE, ZIP CODE PLEY STREET TATION, IN46405		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TA	TIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	glucomete	er. All the					
	glucomete	ers were placed					
	in separat	e boxes in a					
	cart.						
	The Assur	e Platinum					
	User Instruction Manual						
	was reviewed on 5/10/11						
	at 12:15 p.m. The						
	manual indicated that for						
	cleaning, "Healthcare						
	professionals should						
	wear glov	es when					
	cleaning t	he Assure					
	Platinum	meter. Wash					
	hands after taking off						
	gloves. Co	ontact with					
	blood pres						
	•	nfection risk.					
	1	st cleaning the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE: COMPL		
		A. BUI B. WIN	LDING IG		05/11/2		
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
LAKE PARK RESIDENTIAL CARE INC				1	PLEY STREET TATION, IN46405		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	meter bety	ween patients.					
	Clean the	outside of the					
	meter witl	h a lint-free					
	cloth. Dar	npen with					
	soapy wat	er or isopropyl					
	alcohol (7	0 - 85%). To					
	disinfect the meter,						
	dilute 1 ml (milliliter) of						
	household bleach (5%						
	-6%) sodium						
	hypochlor	rite solution) in					
	9 ml of wa	ater. This is a					
	1:10 diluti	ion. The final					
	concentra	tion is 0.5					
	-0.6% sod	lium					
	hypochlorite. Do not						
	clean insid	de the battery					
	compartm	ent or test strip					
	port."						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
I I			A. BUILDING B. WING			05/11/2011	
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE PLEY STREET		
LAKE PA	RK RESIDENTIAL (CARE INC			TATION, IN46405		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	The "Own	ner's Booklet"					
	for the Lib	perty					
	glucomete	er was					
	reviewed	on 5/10/11 at					
	12 30 p.m	. The cleaning					
	instruction	ns indicated the					
	glucometer should be						
	cleaned with a cloth						
	dampened with a soapy						
	solution.						
	Interview	with the					
	Administr	rator on 5/10/11					
	at 2:45 p.r	n., indicated					
	staff should have worn						
	gloves for the cleaning						
	of the glue	cometers. The					
	Administrator was						
	informed	of the User					
	Instruction	n Manual for					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUI		NSTRUCTION 00	COMPL	
			B. WIN			05/11/2	011
NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC				STREET A	DDRESS, CITY, STATE, ZIP CODE PLEY STREET TATION, IN46405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
R0409	the use of disinfection (d) Prior to admiss required to have a including history of infectious diseases resident shows no an infectious stage and yearly thereaft Based on record facility failed to etest was complete sampled resident tuberculin testing (Resident #3) Findings include: The record for Re on 5/9/11 at 10:4 diagnoses include to, chronic obstrudiabetes mellitus renal failure. The to the facility on The resident's currecord was review tuberculin skin te	bleach on solution. ion, each resident shall be health assessment, f significant past or present and a statement that the evidence of tuberculosis in eas verified upon admission ter. review and interview, the ensure a tuberculin skin ed annually for 1 of 11 s who were reviewed for s. esident #3 was reviewed for s. esident #3 was reviewed for sed, but were not limited active pulmonary disease, asthma, and chronic eresident was admitted	RO	1409	Deficiency #409Residents Affected: #31. What correctivaction (s) will be accomplish those residents found to have been affected by the deficier practice? Resident #3 given annual TB test.2. How will the facility identify other resident having the potential to be affected by the same deficient practice and what corrective actions be taken? All residents in the facility have a potential to be affected by alleged deficient practice. Residents are currebeing administered TB tests.3. What measures will put into place or what system changes the facility will make ensure that the deficient practiced on administering all testing at as when due. Director Nursing or designee will compile a list of residents witheir annual due dates for TE testing and will distribute list	ve ed for re ent ve et sected ce will ent to actice be in ITB ctor	DATE 06/23/2011
		d on 5/10/11 at 1:45			nurses to administer.4 How corrective actions will be monitored to ensure the defi		

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 05/11/2	LETED		
NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY STREET LAKE STATION, IN46405					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
TAG	p.m., the facility	Administrator indicated a tuberculin		practice will not recur? Dir Nursing or designee will c monthly listing and will aucompliance. Monitoring wi ongoing.5. By what date is systemic changes will be completed? June 23, 201	ector of heck dit for II be he	DATE		